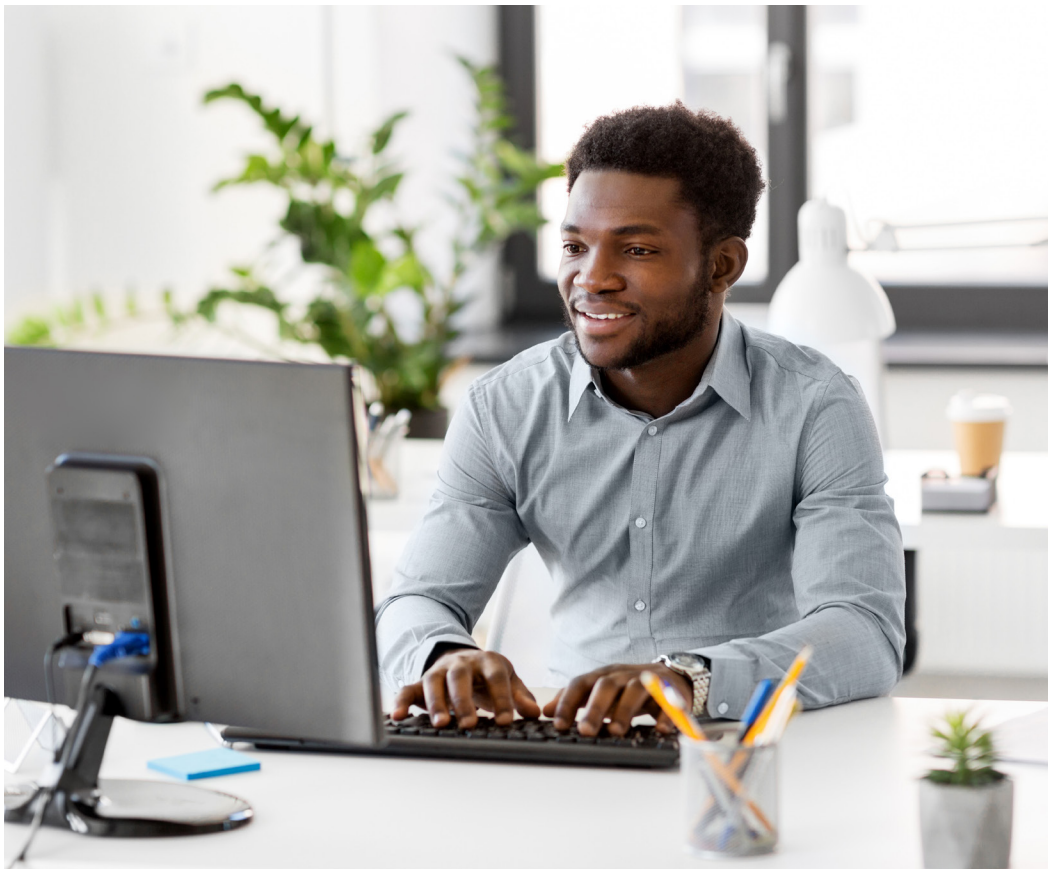
2021

Benefits Administrator Manual



PEBA℠
SC Retirement Systems
and State Health Plan

Table of contents

General information

This manual outlines the rules, regulations, policies and procedures of the S.C. Public Employee Benefit Authority (PEBA), and contains an abbreviated description of insurance benefits offered by or through PEBA.

When determining benefits, the *Plan of Benefits* supersedes all other publications. That document contains a complete description of the State Health Plan. Its terms and conditions govern all health benefits under the Plan. The *Plan of Benefits* is available online at peba.sc.gov/publications. There are also plan documents available for the dental plans and MoneyPlus. For other benefits, the respective contract with PEBA supersedes all other publications.

The *Insurance Benefits Guide* provides details about the various insurance programs offered by PEBA and is available on PEBA's website. The *Insurance Summary* provides a high-level overview of insurance benefits offered by PEBA.

All participating employers must offer their insurance-eligible subscribers all the insurance programs that PEBA offers:

- Health insurance benefits (State Health Plan and the GEA TRICARE Supplement Plan);
- Health and wellness programs;
- Dental insurance (Dental Plus and Basic Dental);
- State Vision Plan;
- Life insurance (Basic, Optional Life and Dependent Life);
- Long term disability (Basic and Supplemental); and
- MoneyPlus (all plans, as eligible).

Employers may not offer competing products and programs that PEBA already offers. Employers may offer products not offered by PEBA; however premiums for those products may not be paid pretax through MoneyPlus.

Benefits administrators and others chosen by the employer who may assist with insurance enrollment, changes, retirement or termination and related activities are not agents of the S.C. Public Employee Benefit Authority and are not authorized to bind the S.C. Public Employee Benefit Authority.

The language used in this document does not create an employment contract between the employee and S.C. Public Employee Benefit Authority. This document does not create any contractual rights or entitlements. The S.C. Public Employee Benefit Authority reserves the right to revise the content of this document, in whole or in part. No promises or assurances, whether written or oral, which are contrary to or inconsistent with the terms of this paragraph create any contract of employment.

How to use this manual

The manual is divided into sections that address Employee Benefits Services (EBS), types of subscribers you assist and insurance billing. A table of contents is included to make it easier to locate the information you need and each section of the manual also includes a contents page.

EBS website

EBS, ebs.eip.sc.gov, is a secure website that gives you instant, online access to insurance benefits information, reporting data and billing reports.

Through EBS, you can:

- View subscriber and spouse and/or child(ren) account and benefits information.
- Enroll new employees and make coverage changes.
- Review and approve changes your employees make using MyBenefits.
- Initiate a request for review.
- Terminate and/or transfer employees' coverage.
- View billing statements and make online payments.
- View enrollment and accounting reports.
- Update SLTD annual salary information, if applicable.
- View other participating employer's contact information.

EBS access is required for participating employers. Refer to the Using the online enrollment system section for information on how to sign up and use the features of EBS.

Contact PEBA

Throughout the manual, you will be referred to PEBA for assistance. Contact the dedicated staff of the Employer Support Center in PEBA's Customer Contact Center at 803.737.6800 or 888.260.9430, Option 4, then Option 2.

Address

202 Arbor Lake Drive
Columbia, SC 29223

Website

peba.sc.gov

Email

Select Contact at the top of peba.sc.gov and select Question about insurance benefits.

Customer Contact Center

803.737.6800 or 888.260.9430

When you call PEBA on behalf of a subscriber

Be sure the subscriber has already attempted to resolve the issue by contacting the third-party claims processor, plan administrator or PEBA. There are excellent online resources available to subscribers, and you should encourage subscribers to use them. If you do need to call PEBA:

- Have the Social Security number (SSN) or Benefits ID Number (BIN) of the individual and your agency group number ready.
- Have your question ready and please be specific.
- Remember HIPAA guidelines. PEBA cannot release personal health information to you, except enrollment and premium information, unless the subscriber has signed an *Authorized Representative Form* and filed it with PEBA, thereby giving you access to his personal health information.

Requests for proof of insurance

Individuals often need proof of health insurance when they travel overseas, particularly if they are students or will be employed in another country. PEBA can provide these letters; however, it may take up to 10 business days to process these requests. Please encourage subscribers to request proof of insurance as soon as they know they need it.

Forms on the web

The forms mentioned in this manual are available at peba.sc.gov/forms. You can view insurance forms either by name or category.

Training and resources

Employer Services and the Field Services team are committed to supporting employers. Staff are available to assist employers with training, seminars, benefit fairs and field visits. An insurance benefits support menu is online at peba.sc.gov/employers. Contact the Employer Services department by email at EmployerServices@peba.sc.gov.

Training classes explain the benefit plans and procedures, and they are designed to help benefits administrators better inform and counsel employees about their insurance coverage and benefits. Benefits administrators and personnel/payroll staff are encouraged to attend. The trainings are offered by PEBA at no charge.

View the presentations and recorded trainings online at peba.sc.gov/insurance-training. The trainings include Insurance Benefits Training, which is an overview of all benefits; COBRA; MoneyPlus; and Retirement, Disability and Death. Additional tutorials on the Request for Review process and SLTD salary updates are also available.

Benefits administrators can register for a class online at peba.sc.gov/events.

Part of the role of the benefits administrator is to inform employees of their benefits. Please take advantage of the publications PEBA produces,

which are all on the PEBA website at peba.sc.gov/publications.

Benefits administrators also have access to the PEBA Health Hub at www.PEBAHealthHub.com. Turnkey marketing toolkits for a variety of topics are available for download.

Using the online enrollment system

Using the online enrollment system

Terms

MyBenefits

MyBenefits is a secure website that allows active subscribers, retirees, survivors, COBRA subscribers and former spouses to access their own enrollment information in PEBA insurance benefits' enrollment database. Through MyBenefits, they can view their enrollment information and make some enrollment changes to their coverage, as well as approve changes you make in EBS and submit to them. Most transactions are paperless, and employees can upload supporting documentation. See Page 26 for more details about MyBenefits.

Summary of Enrollment (SOE)

This document is generated when a new enrollment is completed online.

Summary of Change (SOC)

This document is generated when an enrollment change is completed online.

Notice of Election (NOE)

Some transactions cannot be completed online and require a *Notice of Election* (NOE) form. Find the NOEs at peba.sc.gov/forms.

Summary of Intent (SOI)

This document is generated when an open enrollment change is completed online through MyBenefits. The SOI is a summary of the subscriber's intended changes but does not necessarily display his final choices, because he can make multiple changes online throughout October. At midnight on November 1, PEBA accepts the last change the subscriber submitted.

Summary of Termination

This document is generated when a termination is completed online.

Active Termination Form

Some terminations cannot be completed online and require an *Active Termination Form*. Find the form at peba.sc.gov/forms.

Comptroller General (CG) agencies

Some state agencies process payroll and remittances through the CG's office. For these agencies, some processes are not applicable or differ from other employer types.

Employee Benefits Services (EBS)

PEBA requires all benefits administrators to sign up for EBS, ebs.eip.sc.gov.

Signing up

To access EBS, you need internet access with a compatible browser and Adobe Acrobat Reader software.

A compatible browser

PEBA web applications support the current and previous major releases of Internet Explorer, Chrome, Firefox and Safari running on the Windows or Mac OS operating system. Each time a new version of a browser is released, PEBA begins supporting that version and stops supporting the third-most recent version.

Adobe Acrobat Reader software

Many modern browsers include a built-in PDF viewer. PEBA supports the built-in PDF viewers in Chrome, Firefox and Safari, and it supports the latest version of Adobe Acrobat Reader.

EBS access forms

You must request access to gain a valid user ID and password. The user ID is assigned by PEBA and is a vital part of protecting confidential information. It also is used to track who is using the system, how often and the exact functions used by the individual.

- *EBS Confidentiality Agreement* – Each employer must complete and return this form to PEBA prior to users accessing EBS.
- *EBS Authorizing Agent Designation Form* – Each employer must designate an Authorizing Agent. This person will control

EBS access for employees and any third-party enrollers by completing the appropriate forms. The Authorizing Agent is also responsible for updating the employer's contacts in EBS.

- *EBS Designated Employee Confidentiality Agreement* – This form is required to gain a user ID and password for EBS. Review the provisions on this form carefully. Any violation may result in termination of your EBS access. The Authorizing Agent must approve and sign this form. Select the appropriate systems to access.

If your employer uses a third-party enroller (TPE), two forms must be completed and sent to PEBA:

- *Memo of Understanding (for Third-Party Enrollers)*; and
- *TPE Designated Employee Confidentiality Agreement*.

The EBS access forms are available at peba.sc.gov/forms by category, under Employer.

Once a *Designated Employee Confidentiality Agreement* form is approved by PEBA, a confidential user ID will be sent to you in the mail. A PIN will follow in a separate mailing.

Use the Forgot Password/Unlock Account link at ebs.eip.sc.gov if you need to reset your password or unlock your account, if it is locked or inactive.

To change an employee's access or add a new EBS user, the Authorizing Agent must submit a new *EBS Designated Employee Confidentiality Agreement*.

Annual recertification process

PEBA will notify the Authorizing Agent to complete an annual recertification of EBS users and access. See the Accounting Report EBS950.

EBS homepage

The buttons on the left side of the homepage are accessible to you based on your *Confidentiality Agreement*. If your user ID does not allow access to a function, the button for that function will be grayed out.

- **Inquiry** View detailed insurance information about a subscriber within your group(s). Search by SSN or last name. Also view suspense records for your group.
- **Manage** Enroll new subscribers, make changes to current subscribers or terminate coverage for a subscriber.
- **Enroll. File Upload** Submit a file in PEBA's approved format to initiate online enrollment elections for new hires through MyBenefits.
- **Enroll Reports** View enrollment reports. View information about accounting and enrollment reports in the EBS reports reference.
- **Accounting Reports** View billing statements and reports. View information about accounting and enrollment reports in the EBS reports reference.
- **Balance** View accumulated balance (CG agencies only).
- **Contacts** View contact information of participating employers. Only Authorizing Agents can update contacts.
- **SLTD Salary Entry** Submit SLTD annual salary updates. Available during the open enrollment period. Not applicable to CG agencies.
- **Online Bill Pay** View 12 months of billing statements, remit insurance payments and manage bank accounts.
- **PEBA Insurance Home** Access PEBA's website.
- **Download Forms** Access forms on PEBA's website.
- **Carrier Links** Access insurance resources on PEBA's website.
- **Contact Us** View PEBA's contact information and email PEBA's Customer Contact Center.

- **Browser Support** View information regarding internet browser requirements to use PEBA's online applications.
- **Change Password** Change your password.

BA Console

The BA Console is the tool in the middle section of the EBS homepage that allows you to manage changes to your subscribers' coverage. The results of all enrollment transactions, whether initiated by you or your subscribers, will appear on this console. The console consists of five tabs: Suspended, Acknowledgement, Approval, Current EBS and RFR (Request for Review).

See Page 23 for more information about the BA Console.

Inquiry

Search for coverage information about subscribers from your group by SSN, BIN or name through a Subscriber Inquiry. Subscriber Summary of Change (SOC) documents can also be searched by SSN.

Search for suspense transactions for your group by SSN, BIN or your group number through a Suspense Inquiry.

Manage subscribers

From the Manage Subscribers section on the homepage, you can indicate the type of transaction to be processed or initiate a subscriber or suspense inquiry. Select one of the following actions from the drop-down list:

- Enroll;
- Change;
- Terminate;
- Subscriber Inquiry;
- Suspense Inquiry;
- Subscriber SOCs; or
- Request for Review.

The **Manage** button on the EBS homepage also allows you to enroll, change, terminate or submit a request for review.

Enroll. File Upload

Upload a .csv or .xlsx file if you have multiple new hires. Download a template and access instructions about what you should include in the file and upload a file by selecting this button.

Any formatting or coverage (i.e., currently active with another employer) errors will be returned. Review the error message(s), and correct or remove the employee data from the file before uploading the file again. Please note that if errors exist, none of the data is uploaded to PEBA.

Once the file is uploaded, employees will receive an email from PEBA. Employees should select the link in the email to access MyBenefits. Employees will be prompted to enter their name, date of birth and Social Security number. Employees must also enter an address and make enrollment selections. Employees can choose to upload any supporting documentation, if required. Share the *Insurance Enrollment Guide for New Hires* flyer with employees.

EBS will create a transaction in *Pending Subscriber Enrollment* status on the Suspense tab. Resend the email link to the subscriber by selecting this option on the transaction. If the employee is unable to complete the enrollment online, you may convert the transaction to an EBS Enrollment by selecting this option. You must complete the enrollment (See EBS Enrollment below). You can also edit or delete the transaction, if necessary.

Once the employee submits his enrollment, the transaction moves to the Approval tab with a Pending Employer Approval status. If the employee enrolled in a MoneyPlus account, select the number of annual pay periods from the drop-down list. View or upload any supporting documents. Save or print a copy of the SOE, if needed. Finally, approve the transaction.

The weekly *MyBenefits New Hires* report (HAC475) summarizes the MyBenefits enrollment new hire elections. The report includes an indicator if a new hire does not make his online elections within 31

days of hire. In this case, the new hire defaults to no insurance coverage.

Enroll

Enroll a new employee or an employee transferring from another employer

- From Manage Subscribers, select Enroll from the drop-down list.
- Enter the SSN of the employee.
- Select how to complete the enrollment.
    - By the employee through MyBenefits; or
    - Through EBS.

MyBenefits Enrollment

Complete the required information on the Enrollee Data tab, including a valid email address, salary and date of hire. Select Apply.

The employee will receive an email from PEBA. The employee should select the link in the email to access MyBenefits. The employee will be prompted to enter his name, date of birth and Social Security number. He must also enter an address and make his enrollment selections. The employee can choose to upload any supporting documentation, if required. Share the *Insurance Enrollment Guide for New Hires* flyer with employees.

EBS will create a transaction in *Pending Subscriber Enrollment* status on the Suspense tab. Resend the email link to the subscriber by selecting this option on the transaction. If the employee is unable to complete the enrollment online, you may convert the transaction to an EBS Enrollment by selecting this option. You must complete the enrollment (See EBS Enrollment below). You can also edit or delete the transaction, if necessary.

Once the employee submits his enrollment, the transaction moves to the Approval tab with a Pending Employer Approval status. If the employee enrolled in a MoneyPlus account, select the number of annual pay periods from the drop-down list. View or upload any supporting documents. Save or print a copy of the SOE, if needed. Finally, approve the transaction.

The weekly *MyBenefits New Hires* report (HAC475) summarizes the MyBenefits enrollment new hire elections. The report includes an indicator if a new hire does not make their online elections within 31 days of hire. In this case, the employee defaults to no insurance coverage.

EBS Enrollment

Tabs will appear for you to enter the required information. Because you are entering the information and elections for the employee, it is good practice to have written confirmation of the elections from the employee.

System edits will prompt the required data, return error messages and help text where applicable.

Enrollee Data tab
Complete the required information.

Select Next to move to the Dependents tab.

Dependents tab
If the subscriber is married, the spouse must be listed, regardless of whether the spouse is covered.

If the subscriber is not married and has no eligible child(ren) for whom he is electing benefits, move to the Coverage tab by selecting Next.

If the subscriber was enrolled previously with a spouse or child(ren), the spouse or child(ren) may be selected from the Reactivate Dependent List.

Select the number of dependents from the drop-down list and select Add.

Complete the required information for the dependents. An SSN is required for any child ages 1 or older.

Beside each coverage type, select Activate from the drop-down list or leave the status blank if you are not adding the dependent to the benefits. The system will show the Dependent Life choice based on the relationship entered above.

Enter Other Coverage information, when applicable, if the dependent is enrolling in health coverage. The system defaults to No. If changed to Yes, complete

the required information. The requested date of birth is that of the policyholder of the other plan.

Medicare coverage question defaults to No. If applicable, change to Yes and complete the required information.

You may Add More Rows of dependents by selecting from the drop-down list. The system will add the additional number of fields indicated.

Select Next to move to the Coverage tab.

Coverage tab
Benefit election choices for the Coverage tab will populate based on the information entered on the Dependents tab.

Examples: If no spouse or children are listed, you will not see a choice for Dependent Life. Also, if health coverage is selected for both a spouse and child(ren) on the Dependents tab, the health plan category will default automatically to full family.

If not already populated, select the coverage elections or refuse coverage from the drop-down options.

Tobacco-use defaults to Tobacco Coverage if you elect the Standard or Savings Plan. Change to Refused if the subscriber and dependents do not use tobacco or e-cigarettes.

If electing Optional Life, select the coverage level from the drop-down list. For a new hire, the maximum amount of coverage that may be keyed into the system is three times the employee's salary (rounded down). If the employee wants a higher level of coverage, the employee must complete and submit a MetLife *Statement of Health* form and a paper *Notice of Election* form.

Dependent Life-Spouse will populate automatically, based on whether a spouse was entered on the Dependents tab. Select a coverage level of either $10,000 or $20,000. If the employee wants a higher level of coverage, he must complete and submit a MetLife *Statement of Health* form and a paper *Notice of Election* form. This field will not appear if there is no eligible spouse.

Dependent Life-Child will populate automatically, based on the information entered on the Dependents tab. This field will not appear if there are no eligible children.

If electing SLTD, select the coverage type from the drop-down list. The system will pull the salary from the Enrollee Data tab.

The Pretax Group Insurance Premium feature field will default to Refused but can be changed to Active.

MoneyPlus accounts are listed based upon the health plan selected. Enter the annual contribution amount for each account or leave as $0 to refuse enrollment.

If an annual contribution amount is entered for a MoneyPlus account, enter the Total Annual Pay Periods from the drop-down list.

Select Next to move to the Beneficiaries tab.

Beneficiaries tab
If the desired beneficiary is a spouse or child listed on the Dependents tab, select Add next to Add from existing dependent list. Select the dependent(s) from the list and select Add Selected Dependents to Beneficiaries. The information and relationship of the dependent(s) will populate.

To add more beneficiaries, select the number of beneficiaries from the drop-down list and select Add.

Complete the required beneficiary information, indicate the life insurance program by clicking on the box beside the elected programs, indicate the percentage if not equally divided among the beneficiaries, and select Primary or Contingent from the drop-down list.

Select Next to move to the Review tab.

Review tab
The Review tab is a complete list of all information entered on the previous tabs. The type of action taken and the effective date will be at the top of the page.

From this page you may return to any tab by selecting on the tab at the top of the page if adjustments to the information are needed.

The Summary of Enrollment (SOE) is a complete list of the subscriber's elected benefits, ID data, spouse and child(ren) information and beneficiary information.

Any required documentation will be listed under Supporting Documents.

You may Suspend, Cancel or Apply the transaction by selecting the applicable button (top right of page).

- **Suspend** will allow you to keep what has already been processed, and you may retrieve it later. It will be on the Suspended tab of the BA Console and will be listed as Incomplete. You will receive a SUSPEND message box to add the reason for suspending the transaction.
- **Cancel** will remove the entire transaction. Once you confirm to cancel, it cannot be recovered.
- **Apply** will submit the transaction to either:
    - MyBenefits; or
    - Current EBS.

If you apply the transaction to MyBenefits, an electronic SOE is sent to the employee's MyBenefits account.

The transaction will appear on the BA Console under the Approval tab, pending subscriber approval. The subscriber must log in to MyBenefits to review and complete the transaction.

Notify the employee to log in to MyBenefits, review and approve the transaction, electronically sign and upload any supporting documentation, if required. If there is an error, he can return the transaction to you through MyBenefits for correction. If the subscriber does not upload the supporting documentation, remind him to provide the documentation to you for you to upload.

If the subscriber is a first-time user of MyBenefits, he must first complete the registration process.

Once the subscriber is logged in, the pending transaction will appear immediately. He may select the transaction to review and then choose to Approve or Return the transaction. Once approved, the subscriber can upload any required documentation.

If no documentation is required, the transaction will move from the Approval tab to the Acknowledgement tab on the BA Console. PEBA records will be updated. Once you acknowledge the transaction, a copy of the SOE is available. **Do not mail any documents to PEBA.**

If the subscriber uploaded the required documentation, review the transaction and documents. If needed, upload additional documentation or delete (explanation required). Select Continue on the transaction, and after your review, select Approve. Do not mail any documents to PEBA.

If the subscriber did not upload the required documentation, remind him to provide the required documentation promptly; otherwise the transaction cannot be completed. The transaction will remain on the Approval tab on the BA Console with a Yes for Supp. Docs, and a status of Pending Employer Approval. When you receive the documentation, you may then upload the documents. Approve the transaction.

If the subscriber returns the transaction due to an error or change, the transaction will remain on the Approval tab, but the status changes to Subscriber Returned. You can then edit and resubmit the transaction to return it to the subscriber for approval, or you can delete it, thereby canceling the transaction.

If you apply the transaction to Current EBS, a paper SOE must be signed by a benefits administrator and the subscriber within 31 days of the hire date and returned to PEBA.

If entering information from a signed, paper NOE, be sure to double-check the data entered against the NOE.

From the Current EBS tab on the BA Console, select the transaction.

1. Select Print Signature Sheet to print the barcode signature sheet. The document will open in a new window. The benefits administrator signature and date and the subscriber's signature and date are required on the signature page. The signature page can be uploaded in Step 3.
2. If you need a copy of the SOE for your files or the subscriber, select Print SOE/SOC. The document will open in a new window.

3. Select Continue to review, upload documentation and approve the transaction.

   If you need to edit a transaction, select Edit. Print the revised SOE with the barcode signature sheet, which requires signatures again.

   Review and add any required supporting documentation for the transaction, including the signed barcode signature sheet.

   Drag and drop the file(s) or select Add Docs, then select Upload. The upload will show as complete or an error message will show if the file(s) doesn't meet the upload requirements.

4. Select Approve once the documentation is uploaded. The option for another barcode signature sheet is available.

If you choose to mail the signed barcode signature sheet and required supporting documentation to PEBA, please allow additional time for processing. Place the signed barcode-signature sheet on top and staple any required supporting documentation.

Do not delay in sending the signed barcode signature sheet. The subscriber's file is locked until the signed barcode signature sheet is received, processed, and the transaction is applied by PEBA.

The transaction will be listed as Pending PEBA Approval on the Current EBS tab.

You can review the required supporting documents or view the uploaded supporting documentation up until PEBA approves the transaction. Select the transaction from the Current EBS tab, and then Continue. The required supporting documentation is listed or view the uploaded documents by selecting View.

PEBA applies the transaction once the signed barcode signature sheet, along with any required documentation, is received. The transaction will no longer appear on the Current EBS tab.

Change

You may process most family status changes using EBS. Choices and elections are restricted, based on the selected reason(s) for change. Certain change reasons will result in some fields being populated automatically. Other fields and tabs will be hidden or grayed out.

The effective dates are calculated automatically based on the information entered on the Define Your Change screen. A summary of the changes can be viewed on the Review tab and on the Summary of Change (SOC).

Required documentation is based on the change reason and/or the spouse or child(ren)'s eligibility status and can be uploaded through MyBenefits or EBS.

Make changes to current subscriber(s):

1. From Manage Subscribers, select Change from the drop-down list. Enter the subscriber's SSN and select Go.

2. Select the Reason for Change from the drop-down list. You may be prompted to select a sub-reason from the drop-down list.

   The reason and/or sub-reason will generate instructions and basic requirements, as applicable.

If the change is due to a special eligibility situation, a new field, Date of Request, may appear. The Date of Request field is pre-filled with the current date. Adjust this date only if necessary.

3. Select Next.

The Enrollee Data tab will then appear.

Enrollee Data tab
The Enrollee Data information may be updated with any change type.

- Address changes processed using the Current EBS method require both the subscriber and the benefits administrator signatures.
- Changes to the subscriber's SSN or date of birth must be made on a paper NOE with the supporting documentation included.

Select Next to move to the Dependents tab.

Dependents tab
Based on the change reason, change the coverage status for an existing spouse and children and/or enter any new dependents.

Please note for the following change reasons:

- **Ineligible dependent child(ren)** Changing eligibility to Ineligible terminates all coverage for the child(ren).
- **Dependent deceased** Marking the Deceased box terminates all coverage for the deceased spouse or child(ren).
- **Dependent gain of other coverage** (state or non-state) Terminate only those benefits gained elsewhere with the Coverage Status drop-down list.
- **Dependent loss of other coverage** (state or non-state) Add only those benefits lost elsewhere with the Coverage Status drop-down list. Loss of state benefits for a spouse will allow adding Dependent Life-Spouse coverage.
- **Family status changes** Previously covered child(ren) may be chosen from the Reactivate Dependent List and their benefits activated.

Select Next to move to the Coverage tab, if applicable.

Coverage tab
Based on the change reason, information will be pre-filled. Only fields with a white background may be edited.

Please note for the following change reasons:

- **Marriage, newborn, adoption, custody** Optional Life benefits may be selected or increased, and a new coverage level may be chosen from the drop-down list where the maximum amount available without evidence of insurability is displayed.
- **Elections or increases of Optional Life coverage levels with evidence of insurability** A *Statement of Health* form must be completed and sent to MetLife for review.

  For those who participate in the Pretax Group Insurance Premium feature, action must be requested within 31 days of a family status change or during enrollment periods in which participants can select or increase coverage, without medical evidence, above the amount available. Approvals from MetLife should be forwarded directly to PEBA with an NOE and supporting documentation.

  For those who do not participate in the Pretax Group Insurance Premium feature , requests may be processed through EBS and forwarded to PEBA with the SOC, approval letter from MetLife and supporting documentation. These requests may be made throughout the year.

Select Next to move to the Beneficiaries tab, if applicable.

Beneficiaries tab
Based on the change reason, make changes as needed. Select Delete to remove a beneficiary.

If the desired beneficiary is a spouse or child listed on the Dependents tab, select Add next to Add from existing dependent list. Select the dependent(s) from the list and select Add Selected Dependents to Beneficiaries. The information and relationship of the dependent(s) will populate.

To add more beneficiaries, select the number of beneficiaries from the drop-down list and select Add.

Complete the required beneficiary information, indicate the life insurance program by clicking on the box beside the elected programs, indicate the percentage if not equally divided among the beneficiaries, and select Primary or Contingent from the drop-down list.

Select Next to move to the Review tab.

Review tab
The Review tab is a complete list of all information entered on the previous tabs. The type of change and the effective date will be at the top of the page.

From this page, you may return to any tab by selecting the tab at the top of the page if adjustments to the information are needed.

The Summary of Change (SOC) is a complete list of the subscriber's elected benefits, ID data, spouse and child(ren) information and beneficiary information. Both the old values and the new values, created by the transaction, will be displayed.

Any documentation that is required will be listed under Supporting Documents.

You may Suspend, Cancel or Apply the transaction by selecting the desired button (top right of page).

- **Suspend** will allow you to keep what has already been processed, and you may retrieve it later. It will be on the Suspended tab of the BA Console in an Incomplete status. You will receive a SUSPEND message box to add the reason for suspending the transaction.
- **Cancel** will remove the entire transaction. Once you confirm cancellation, it cannot be recovered.
- **Apply** will submit the transaction and choose either
    - MyBenefits; or
    - Current EBS.

If you apply the transaction to MyBenefits, an electronic SOC is sent to the employee's MyBenefits account. See Page 18 for more information on this process.

If you apply the transaction to Current EBS, a paper SOC must be signed by the benefits administrator and the subscriber within 31 days and returned to PEBA. See Page 19 for more information on this process.

An address change processed through the Current EBS method requires both the subscriber and the benefits administrator signatures.

Terminate

Unlike the enrollment and change processes, terminations are submitted directly to PEBA without the suspense process. PEBA's files are updated immediately for billing and transmission to the carriers.

Some types of terminations must be sent to PEBA on an *Active Termination Form*. See Page 23 for termination reasons that require this form.

Under Manage Subscribers, select Terminate from the drop-down list. Enter the subscriber's SSN and select Go. The Terminate Coverage tab will then appear.

Terminate Coverage tab
Select the Reason for Termination from the drop-down list. Enter the effective date and any additional information, if prompted to do so.

Select Next to move to the Review tab.

Review tab
The Review tab will include status and effective date changes. It also will have reminders about COBRA notification, continuation, conversion and MoneyPlus. Mark any applicable items.

Select Apply to complete the termination. Save or reprint the Summary of Termination (SOT), for your files and the subscriber.

The termination form is transmitted to PEBA. Do not mail any documents to PEBA.

Request for Review

Complete a request for review (RFR) for new hires, newborns, marriage, divorce, adoption, gain or loss of health, dental and/or vision coverage not administered by PEBA, and gain or loss of PEBA-administered insurance benefits.

Under Manage Subscribers, select Request for Review from the drop-down list. Enter the subscriber's SSN and select *Go*.

If there is a pending transaction for the subscriber, you will be alerted that the record has a pending suspense transaction. It will allow you to delete and rekey the transaction through the request for review process.

Select the change reason from the drop-down list. Enter the event date, requested effective date and the reason for review. Your phone number is not required, however, PEBA encourages you to enter your phone number in case more information is needed.

In the *S*ummary of change section, enter coverage change that is being requested. Then, enter a detailed explanation of the circumstances behind the request.

Once you select Next, you will be prompted to complete the process as you would a normal transaction. Once applied, the RFR transaction is on the RFR tab in Pending Employer Approval status. Select the transaction to:

- Save or print the barcode signature sheet;
- Save or print a copy of the SOE/SOC for your files or the subscriber;
- Print a copy of the Request for Review;
- Edit the transaction;
- Delete the transaction; or
- Select Continue to review, upload supporting documentation, including the signed Signature Sheet, and approve the transaction.

Once approved, the status changes to Pending PEBA Approval.

If the RFR is approved, the transaction will apply with the requested effective date and the transaction will no longer appear on your RFR tab.

If the RFR is rejected, an explanation of what needs to be done to correct the error will be shown on the suspended transaction.

If it is denied, the status changes to PEBA Denied . View the RFR Denial and denial reason and save or print prior to your acknowledgement. You must provide a the employee a copy of the denial request to notify the employee of his right to an appeal. Remember to place a copy of the denial in the employee's file.

View a brief RFR tutorial at peba.sc.gov/insurance-training.

Manual transactions

Due to system limitations, there are some transactions that must be submitted on a paper NOE.

Enrollments/re-enrollments

- Election changes if new hire changes his mind within 31 days, if the first enrollment has already been approved by the employer. Enrolling new hire if employee is currently covered as a dependent on another subscriber's coverage.
- Enrolling retirees, survivors, COBRA subscribers and former spouses.
- Enrolling working retiree in active coverage.
- Enrolling an active subscriber on stipend.

- Open enrollment changes that may require two transactions, such as family status changes with effective dates in October, November or December.

Dependents

- Adding incapacitated children to coverage.
- Enrolling or keying a change for a subscriber with a National Medical Support Notice dependent.

Changes

- Social Security numbers.
- Dates of birth.
- For a subscriber who has a covered child turning age 26 prior to the change effective date.
- For a subscriber who has a covered child on Dependent Life-Child coverage turning age 25 prior to the change effective date.
- For a stipend subscriber.
- For a subscriber covering a child with a relationship code of "Temporary Custody Pending Adoption," whose end date is prior to change effective date.
- For a subscriber who already has an effective date on file that is after the new change effective date (newborn to be added in November after open enrollment has processed.)

Terminations

- Due to non-payment, military leave or those more than 31 days retroactive.
- Due to Supplemental Long Term Disability in a waiver of premium status.

EBS forms

- Authorization and recertifications.

BA Console

The BA Console consists of five tabs: Suspended, Acknowledgement, Approval, Current EBS, and RFR (Request for Review). From the BA Console, follow up on transactions initiated by you in EBS, as well as transactions initiated by subscribers in MyBenefits.

You can change the number of transactions displayed on the tabs (10, 25, 50 or 100).

Suspended tab

This tab includes transactions that have been suspended by the employer and are in an Incomplete status. You can suspend a transaction for any number of reasons, including missing supporting documentation.

Incomplete transactions may be edited or deleted. Select anywhere on the row of a transaction to open it.

- **Edit** allows you to make changes or corrections to the subscriber's data. Once you have made changes, review and apply to generate a revised SOC. The revised SOC must be submitted to PEBA, along with any required documentation. If you edit a transaction prior to approving, another barcode signature sheet must be submitted to PEBA**.** The latest edited transaction must be signed and dated by you and the subscriber before submitting to PEBA.
- **Delete** removes the transaction. Deleting a transaction before it is applied by PEBA will cancel the transaction, and it will disappear from the Suspended tab.

Transactions more than 31 days old are highlighted in yellow.

The transaction status will change from Incomplete to Complete and move to the Approval tab or Current EBS tab for completion once you finish processing the transaction.

At 60 days, a suspended transaction is canceled automatically, and it is deleted. The transaction is not applied. If the transaction is still valid, you need to submit a request for review.

Acknowledgement tab

This tab includes transactions that are initiated by subscribers using MyBenefits or initiated by you and sent to subscribers to approve electronically in

MyBenefits. These transactions do not require documentation. Examples include:

- New hire enrollments that do not require documentation.
- Contact information (address, phone numbers, email address) changes; and
- Beneficiary changes.

Select anywhere on the row of a transaction to open it. When you acknowledge the transaction, a new window opens with the SOE/SOC to save or print. Do not mail any documents to PEBA.

Transactions more than 31 days old are highlighted in yellow.

Transactions that are 60 days old are removed from the Acknowledgement tab automatically. However, these transactions were applied at the time the subscribers made them.

Acknowledging these transactions will remove them from the Acknowledgement tab. Notify any other applicable parties of the address changes.

Approval tab

This tab includes transactions that are initiated by subscribers using MyBenefits or initiated by you and sent to subscribers to approve electronically in MyBenefits. The Status (third column) and Support Documents (fourth column) information is vital in handling these transactions.

These transactions are not applied by PEBA or sent to the third-party claims processors until after you approve them.

You must approve (or reject) these transactions in time to allow your subscribers to correct their changes or to change their minds (either through MyBenefits or by completing a paper *Notice of Election*) before the end of the enrollment period on October 31 or a 31-day election period.

Records that have been rejected by PEBA are highlighted in green and appear at the top of the list for your immediate attention.

Transactions more than 31 days old are highlighted in yellow.

At 60 days, a pending transaction is canceled automatically, and it is deleted. The transaction is not applied.

Current EBS tab

This tab includes transactions that are initiated by you and require signatures. Select anywhere on the row of a transaction to open it. To print the barcode signature sheet, select Print Signature Sheet.

If you need a copy of the SOE/SOC for your files or the subscriber, select Print SOE/SOC. Select Edit to make any necessary changes. Select Continue to review, upload documentation, including the signed barcode signature sheet and approve the transaction.

PEBA applies the transaction once the signed barcode signature sheet, along with any required documentation, is received. The transaction will no longer appear on the Current EBS tab.

RFR (Request for Review) tab

This tab includes request for review, or RFR, transactions that are initiated online by the employer.

Review the tab for rejected or denied RFR transactions.

Status

Transaction statuses are explained below.

Pending Subscriber Enrollment

Transactions on the Suspended tab that are created by a MyBenefits Enrollment.

Resend the email link to the subscriber by selecting this option on the transaction.

If the employee is unable to complete the enrollment online, you may convert the transaction to an EBS Enrollment by selecting this option. You must complete the enrollment.

You can also edit or delete the transaction, if necessary.

Once the employee submits his enrollment, the transaction moves to the Approval tab with a Pending Employer Approval status.

Pending Subscriber Approval

Transactions initiated by the employer and sent to the subscriber to approve in MyBenefits. You may review or delete the transaction but cannot make changes.

Notify the employee to log in to MyBenefits, review and approve the transaction and electronically sign.

No documentation required
Once approved by the subscriber, the transaction will move to the Acknowledgement Tab on the BA Console. PEBA's records are updated.

Documentation required
The subscriber can upload any required documentation in MyBenefits. Once approved by the subscriber, the transaction status changes to Pending Employer Approval.

Pending Employer Approval

Select Continue to review and approve the transaction. You may save or print the SOE/SOC.

Delete the transaction, if necessary. The enrollment/change is then canceled.

No documentation required
PEBA's records are updated once you approve the transaction.

Documentation required
Review any uploaded documentation by the subscriber or if the subscriber provides you with the documentation, upload the documents. The transaction status changes to Pending PEBA Approval.

If the required documentation is not uploaded, a barcode page is generated. Print and send only this barcode page with the documentation attached. Do not include a copy of the SOE/SOC.

Pending PEBA Approval

Transactions approved by the employer and for which supporting documentation is uploaded. You may review and save or print a copy of the SOE/SOC or barcode page up until PEBA approves the transaction.

PEBA's records are updated once the supporting documentation is approved by PEBA. If the documentation submitted is incomplete or insufficient, PEBA will reject or remove the transaction.

Subscriber Returned

Documentation may or may not be required
Transactions initiated by the employer and sent to the subscriber to approve in MyBenefits; however, the subscriber returned the transaction because of an error or change.

Select the transaction to view the subscriber's message for the correction(s) he is requesting.

Select Edit to send it back to the subscriber to review and approve in MyBenefits.

Select Review to view and print a copy of the SOE/SOC without making any changes to the document. After review, select Approve.

Your approval updates PEBA's records and sends a copy of the transaction to the appropriate third-party claims processors.

Delete the transaction, if necessary. The enrollment/change is then canceled.

PEBA Rejected

Transactions that PEBA has returned to the BA Console because the supporting documentation was incomplete or insufficient. Highlighted in green at the top of the Approval tab.

Select the transaction to view the rejection reason. Obtain and upload the additional or corrected documentation. You may also need to upload a copy of the original SOE/SOC as verification of the date the subscriber initially tried to make the

change. Approve the transaction. The transaction status changes back to Pending PEBA Approval.

If the required documentation is not uploaded, a barcode page is generated. Print and send this barcode page with the documentation attached.

Delete the transaction, if necessary. The enrollment/change is canceled.

PEBA Denied

RFR (Request for Review) transactions that are denied by PEBA. View the RFR Denial and denial reason, and save or print prior to your acknowledgement. You must provide the employee a copy of the denial request to notify the employee of his right to an appeal. Remember to place a copy of the denial in the employee's file.

Incomplete

Transactions on the Suspended tab that have been suspended by the employer. Incomplete transactions may be edited or deleted.

Advanced Key

Transactions with future effective dates are stored once keyed until PEBA runs the billing that coordinates with the date of the transaction.

Error

Transactions are marked as an error if they are rejected.

Tips

If you need to save or print an SOE/SOC but do not see it on your screen after you apply the transaction, check the bottom toolbar or behind other windows on your screen. Sometimes the document will minimize.

Upload barcode signature sheets as soon as possible. If the employee is not available to sign, have him complete and sign a paper NOE and upload it with the SOE/SOC.

Do not write additional instructions on an SOE/SOC. PEBA cannot key handwritten changes. Re-key the transaction in EBS.

Notify your payroll department of any changes that affect premiums.

Save or print any rejected transactions.

If a NOE is required because of a rejection, include a copy of the original SOE/SOC with the NOE. This verifies the original request was made within 31 days.

MyBenefits

MyBenefits allows subscribers to access their insurance information online and make some changes on their own. MyBenefits also allows subscribers to upload supporting documentation.

You can view subscriber changes made through MyBenefits on the BA Console.

When contact or beneficiary information is changed, you will receive a notice on the Acknowledgement tab.

During open enrollment, subscribers can make coverage changes for the next year. Depending upon the type of change, you will receive a notice on the Approval tab.

Using MyBenefits

A step-by-step flyer on how to register for MyBenefits can be found at peba.sc.gov/nyb.

After logging in, the subscriber will see any transactions you submit for his approval, or he may choose to review his benefits, update his contact information, initiate changes as a result of a special eligibility situation, review and change his beneficiaries, and make changes during the open enrollment period.

When a subscriber initiates a change using MyBenefits, a Summary of Change (SOC) is generated, similar to what is generated in EBS. Changes and updates are in the New Value fields. To accept the change(s), he selects Approve. A certification, authorization and disclaimer statements appear, which require an electronic signature. The subscriber enters the last four digits

of his SSN to authorize and process the change. A final SOC is generated that the subscriber can save or print for his records.

You can access SOEs and SOCs initiated in MyBenefits. Under Manage Subscribers, select Subscriber SOCs and enter the subscriber's SSN. Select Go. Select the PDF file under the SOC column.

Making special eligibility changes

Subscribers can make changes using MyBenefits when a special eligibility situation occurs, such as adding a newborn, marriage, divorce or adoption. MyBenefits will display the documentation required for each change, which can be uploaded through MyBenefits.

Making open enrollment changes

During open enrollment, subscribers can make changes in MyBenefits, as permitted during the open enrollment period.

Your Current Coverage

Details the subscriber's coverage and coverage levels.

Make Coverage Changes

The subscriber can enroll, change and cancel coverage for the programs allowed. Edits prevent the subscriber from enrolling in a program for which he, his spouse or his child(ren) is not eligible or from selecting a level of coverage above what is allowable.

Dependents

The subscriber can review his spouse and/or child(ren) and their coverage, add a spouse and/or child(ren), or add or cancel coverage for his spouse and/or each child by program, as allowed.

Beneficiaries

Details the subscriber's current beneficiaries. He can add or delete beneficiaries, designate them as primary or contingent and change the percentages for Basic Life and Optional Life.

Completing open enrollment changes

Once a subscriber has completed his change(s), he will be prompted to review the change(s) before electronically authorizing and submitting. A Summary of Intent (SOI) is generated that the subscriber can save or print for his records.

The enrollment change(s) will be sent to the Approval tab of the BA Console.

If the subscriber changes his mind during open enrollment

If a subscriber changes his mind about his elections, he may go into MyBenefits and edit and/or delete his changes until 11:59 p.m. on October 31, regardless of whether the transaction has been approved by his employer.

If his employer has approved a previous transaction, a new status will appear on the Approval tab as Pending Employer Approval-Subscriber Changed.

The deadline for all open enrollment changes is October 31.

Active subscribers

Active subscribers

Employee eligibility rules and procedures

The *Plan of Benefits* defines an employee as:
A person employed by an Employer on a Full-Time basis, and who receives compensation from a department, agency, board, commission or institution of the State, including clerical and administrative Employees of the General Assembly, and judges in the State courts. Retirees who return to work with an Employer are considered Employees for purposes of eligibility under the Plan. For purposes of this Plan, the term shall include other Employees that the General Assembly has made eligible for coverage by law, including Employees of a public school district, county, municipality, or other Employer that has qualified for and is participating in, coverage under the Plan. The members of the South Carolina General Assembly and elected members of the councils of participating counties or municipalities, whose council members are eligible to participate in the South Carolina Retirement Systems, and Part-Time Teachers, are also Employees for purposes of the Plan.

The *Plan of Benefits* defines full-time as:
With regard to an Employee, shall mean an employee who is credited with an average of at least 30 hours of service per week. An employer may exercise a one-time, irrevocable option to elect the definition of Full-Time to mean an employee who is credited with an average of at least 20 hours per week, and to apply this definition, upon notification and acceptance by PEBA. Full-time status for purposes of eligibility to participate in the Plan is determined in accordance with the process set out in paragraphs 3.22, 3.23, and 3.24 of the Plan.

Determining eligibility for benefits

The Affordable Care Act (ACA) requires all Applicable Large Employers to offer health insurance that is affordable and provides minimum value to all full-time employees or pay a penalty to the IRS.

To accommodate this requirement, participating employers must offer coverage to any employee who meets the eligibility requirements established by the ACA.

All employees fall into one of three categories:

- **New full-time employee (Permanent or Nonpermanent)** A newly hired employee who was determined by the employer, as of the date of hire, to be full-time and eligible for benefits. The employee is eligible to enroll in coverage within 31 days of his hire date.
- **New variable-hour, part-time or seasonal employee** A newly hired employee who is not expected to be credited an average of 30 hours per week for the entire measurement period, as of the date of hire. Therefore, the employer cannot reasonably determine his eligibility for benefits as of the date of hire. The employer must measure the employee's hours to determine whether the employee will be eligible for benefits.
- **Ongoing employee** Any employee who has worked with an employer for an entire Standard Measurement Period (see below).

To assist employers with determining an employee's eligibility for benefits, the IRS has established three safe harbor regulations: Measurement Periods, Administrative Periods and Stability Periods.

Measurement periods

A measurement period is the 12-month period of time an employer uses to review the number of hours worked by an employee to determine eligibility for benefits.

There are two types of measurement periods: Initial Measurement Period and Standard Measurement Period.

An **Initial Measurement Period** applies to any newly hired variable-hour, part-time or seasonal employee. An Initial Measurement Period begins the first of the month after the date of hire and ends 12 months later. The employer would not offer benefits to a newly hired variable-hour, part-time or seasonal employee at the time of hire, instead the employer would review the employee's hours over the Initial Measurement Period to determine eligibility.

The **Standard Measurement Period** applies to all ongoing employees and begins on October 4 of each calendar year and ends on October 3 of the next calendar year. For Plan Year 2021, the Standard Measurement Period runs from October 4, 2020, and ends on October 3, 2021.

Administrative periods

The Administrative Period is the period of time (immediately after the measurement period) when the employer notifies an employee of his eligibility for benefits and the plan processes the employee's enrollment.

There are two types of administrative periods.

Initial Administrative Period

A new variable-hour, part-time or seasonal employee credited with an average of 30 hours per week during his Initial Measurement Period may enroll during an Initial Administrative Period, which begins the day after the end of his Initial Measurement Period and ends the last day of the same month. Coverage begins the first of the month after the end of the Initial Administrative Period.

For example, if a variable hour/part-time employee is hired June 3, his Initial Measurement Period is July 1 through June 30 of the following year. The Initial Administrative Period is during that following July. Throughout this Initial Administrative Period, the employer should review hours worked during the Initial Measurement Period to determine if the employee averaged 30 hours per week.

Standard Administrative Period

The ACA requires employers to monitor the hours of all employees to ensure eligible employees are offered benefits. An ongoing employee credited with an average of 30 hours per week during the Standard Measurement Period may enroll annually during the October enrollment period with coverage effective January 1.

The Standard Administrative Period for plan year 2021 is October 3, 2021 to December 31, 2021. Employers, however, must determine eligibility and offer coverage to eligible employees during the plan's open enrollment period, which ends October 31, 2021. All enrollments must be submitted to PEBA according to the open enrollment submission deadline (refer to Page 27 open enrollment). PEBA will use the remainder of the Standard Administrative Period (November to December 31) to process enrollments to ensure employees have access to coverage at the beginning of the Stability Period (January 1, 2021).

The Standard Administrative Period is also the period of time an employer must notify an employee of his loss of eligibility for the next plan year. If an employee previously determined as eligible for coverage during the Initial Administrative Period is determined not to have met the average of 30 hours per week during the Standard Measurement Period, the employee will lose eligibility at the end of his stability period.

Ongoing employee

If the employee is an ongoing employee and he does not qualify for benefits in the next plan year, the employee will lose eligibility at the end of the current plan year. You should:

- Notify the employee he will not be eligible for benefits in the next plan year;
- If the employee is enrolled in health, dental or vision, send the employee and his covered dependents an 18-month COBRA Notice. The COBRA Qualifying Event will be the employee's reduction of hours effective January 1; and

- Submit the termination in EBS. For the termination reason, choose Left Employment.

New variable-hour, part-time or seasonal employee

If the employee is a new variable-hour, part-time or seasonal employee and he does not qualify for benefits based on the Standard Measurement Period, the employee will lose eligibility at the end of his Initial Stability Period. During the Standard Administrative Period, you should notify the employee he will not be eligible for benefits when his Initial Stability Period ends. At the end of the employee's Initial Stability Period, you should:

- Notify the employee of his loss of eligibility;
- If the employee is enrolled in health, dental or vision, send the employee and his covered dependents an 18-month COBRA Notice. The COBRA Qualifying Event will be the employee's reduction of hours effective the end of his Initial Stability Period; and
- Submit the termination in EBS. For the termination reason, choose Left Employment.

Stability periods

The Stability Period is the period of time an employee remains eligible, regardless of the number of hours worked.

An Initial Stability Period for New Variable Hour, Part-Time and Seasonal Employees begins the first of the calendar month after the end of the Initial Administrative Period and ends the day before in the following calendar year. For example, an Initial Stability Period that begins on May 1 of one year would last until April 30 of the following calendar year.

A Standard Stability Period for Ongoing Employees begins January 1 of each year and ends on the following December 31.

Notes on employee eligibility

- An employee who returns to the same employer with no break in coverage or with no more than a 15-calendar-day break in employment is considered a transfer, not a new hire. For a break in service of greater than 15 calendar days, but less than 13 calendar weeks (26 weeks for academic employers), see the ACA reporting requirements frequently asked questions.
- An academic employee (public school districts, universities, colleges and technical colleges) who completes a school term and moves to another academic setting with another participating academic employer at the beginning of the next school term is a transfer, not a new hire.
- Eligibility for benefits is based on the number of hours the employee works for an employer. If an employee works for more than one participating entity that shares a common payroll center (i.e., CG agencies), the hours worked for both agencies should be combined to determine eligibility. In the case of a tie, both employers should offer coverage, and the employee can choose from which employer to accept coverage. See the ACA reporting requirements frequently asked questions.
- An employee who works for two participating employers is considered working for one employer or the other employer for insurance purposes. His insurance coverage and premiums *cannot* be split between the two employers, nor may he combine his two salaries for Optional Life/Dependent Life Insurance purposes. See Page 64, Transfers and Terminations, for additional information.
- There are other special provisions regarding calculating hours of service and eligibility for benefits, especially for academic employers. PEBA strongly encourages employers to consult with their legal

counsel for guidance in calculating hours of service.

Active nonpermanent full-time employees are eligible for the same insurance benefits as active permanent full-time employees. They are enrolled in benefits using an Active NOE, not a Part-time NOE. In the Eligible due to the Affordable Care Act box on the Active NOE, check Full-time nonpermanent.

While nonpermanent full-time employees are eligible for active employee insurance benefits, they may not be eligible for retiree coverage if they retire from a nonpermanent position. See Page 87 for retiree eligibility requirements, including that the last five years of active employment must be full-time, permanent and consecutive.

Note: PEBA does not verify the eligibility of employees for employers. Neither does it classify employees.

Procedures to elect 20-hour threshold

Any participating employer has the option of reducing the threshold for insurance eligibility for all full-time employees from 30 hours per week to at least 20 hours per week.

To elect the 20-hour threshold, the director/head of the participating employer must send a letter to PEBA requesting this option. The letter should acknowledge the guidelines below. The director/head must sign the letter, and the original should be sent to the Operations manager at PEBA (address on Page 9).

PEBA will send back a letter acknowledging receipt of the request. This letter will restate the guidelines below and will include the date the change to 20 hours will go into effect.

Guidelines for extending benefits to 20-hour employees

- Benefits must be offered to **all** employees working 20 or more hours per week.
- The decision to extend benefits to employees working 20 or more hours per week is **irrevocable**.
- Employees working 20 or more hours per week are entitled to participate in the same state benefits available to other full-time employees.
- The minimum employer contribution for these employees is the same as for other full-time employees.

Assisting a benefits-eligible employee

Use the *Enrolling a new hire* checklist at peba.sc.gov/publications under *Life event checklists*.

You may also prepare an information packet as outlined below.

Required information

When an employee becomes eligible for insurance benefits, provide the employee with the following items that are available online at peba.sc.gov/new-employees:

- Federally mandated notices;
- *Insurance Summary*;
- *Insurance Enrollment Guide for New Hires* flyer;
- *Setting Up a New MyBenefits Account* flyer;

You should also provide the *Marketplace Exchange Notice* and *Notice of Special Enrollment Rights*.

If system limitations prevent electronic enrollment and you are enrolling on paper, provide:

- *Active Notice of Election* (NOE); and
- *Certification Regarding Tobacco or E-cigarette Use*.

Review benefits available

Explain the following benefits are available to all eligible employees. The new employee must choose or refuse each of the following, based on eligibility:

Health insurance

State Health Plan (includes prescription drugs and mental health/substance use; includes an additional preventive benefit for Savings Plan).

Subscribers of the State Health Plan are also eligible for PEBA Perks, value-based benefits at no cost.

Explain the premium for tobacco or e-cigarette users, which is automatic for State Health Plan subscribers, unless subscriber certifies he nor anyone he covers uses tobacco or e-cigarettes, or covered individuals who use tobacco or e-cigarettes have completed a tobacco cessation program approved by PEBA. See Page 35 for more information.

GEA TRICARE Supplement Plan is available to members of the military community.

Dental insurance

- Dental Plus; or
- Basic Dental.

Vision care

- State Vision Plan.

Life insurance

- Automatic enrollment in Basic Life with AD&D, at no cost, if enrolled in health insurance.
- Optional Life with AD&D;
- Dependent Life-Spouse with AD&D; and
- Dependent Life-Child (a child ages 19-24 must be a full-time student or certified as incapacitated to be eligible for coverage; a child older than 24 must be certified as incapacitated to be eligible for coverage).

Long term disability insurance

- Automatic enrollment in Basic Long Term Disability, at no cost, if enrolled in health insurance.
- Supplemental Long Term Disability (SLTD).

There is a 12-month preexisting condition exclusion period related to BLTD and SLTD benefits.

Any applicable late entrant procedures and the preexisting exclusion period is 12 months for late entrants to SLTD.

MoneyPlus

- Pretax Group Insurance Premium feature for health, Dental Plus, Basic Dental, State Vision Plan and up to $50,000 in Optional Life coverage.
- Medical Spending Account (MSA).
- Limited-use Medical Spending Account.
- Dependent Care Spending Account (DCSA).
- Health Savings Account (HSA).

Review network, preauthorization, claims requirements

Explain the State Health Plan requirements for Medi-Call, mental health and substance use benefits, maternity management benefits, Pap test benefit, advanced radiology scans (such as, but not limited to, CT, MRI, MRA, PET scans), the hospital and physician networks, the Prescription Drug Program networks and the well-child benefit.

Explain the claims processing steps for benefits, including how to file manual claims, and that completed claim forms should be submitted as services are rendered. Forms are available online at peba.sc.gov/forms.

Contact BlueCross BlueShield of South Carolina if enrolling in PEBA health benefits while also remaining covered under another health plan for coordination of benefits.

Explain how to request reimbursements from MoneyPlus accounts for unreimbursed expenses.

Explain how to access digital identification cards or replace cards using the BlueCross, Express Scripts and EyeMed apps.

Refusal of coverage

An employee may refuse to enroll in any or all of the benefits plans offered by the state. **If an employee refuses health coverage, he forfeits Basic Life and Basic Long Term Disability coverage.**

To refuse coverage, an enrollment indicating **Refuse** must be submitted to PEBA.

If an employee is already enrolled as a dependent on his parent's coverage through PEBA, he may continue coverage as a dependent or enroll in coverage as an active employee. If the employee chooses to remain enrolled as a dependent, he may not enroll in any benefits as an employee, including SLTD and Optional Life.

The benefits administrator should have the employee complete and sign a paper NOE refusing all coverage. Under Type of Change on the NOE, next to Other, specify *Enrolled as child of PEBA subscriber*.

Explain enrollment deadlines

Enrollments must be completed and authorized within 31 days of date of hire or a special eligibility situation.

If not completed within 31 days, the employee must wait until the next open enrollment period or a special eligibility situation to enroll in health, dental and/or vision coverage. At that time, full-time employees may be required to provide evidence of insurability to enroll in Optional Life and Dependent Life-Spouse and medical evidence of good health to enroll in SLTD coverage.

The new employee can change his mind about an original selection within 31 calendar days of his date of hire (not the effective date of coverage). To make a new selection, a paper NOE must be signed within the 31-day window and submitted to PEBA for processing. Indicate on the NOE that it is a revision within 31 calendar days.

Explain effective dates

New full-time employees

If the employee's first scheduled workday is the *first calendar day* of the month, coverage begins that day (on the first of the month).

If the employee's first scheduled workday is the *first working day* of the month (first day of the month that is not a Saturday, Sunday or observed holiday), but not on the *first calendar day* of the month (for example, he begins on the 2nd or 3rd of the month), then the employee may choose when coverage begins:

- The first day of that month, or
- The first day of the following month.

If the employee's first scheduled workday is *after the first calendar day and after the first working day of the month* (after the first day that is not a Saturday, Sunday or observed holiday), coverage will begin the first day of the *following* month.

Coverage of the spouse and/or children will become effective when the new employee's coverage becomes effective.

Life insurance coverage is subject to the Dependent Non-confinement Provision, as well as the Actively at Work requirement.

Explain any applicable late entrant procedures, open enrollment and special eligibility situations.

Tobacco certification

To avoid paying the tobacco-use premium, new employees must certify that neither they nor their covered spouse and/or children use tobacco products or electronic cigarettes.

When completing an electronic enrollment through MyBenefits or Current EBS, the tobacco and e-cigarette use certification is submitted as part of the enrollment. The certification form is not required. The effective date for the waiver (or premium if certifying as tobacco or e-cigarette user) will be the effective date of coverage.

- Subscribers may also follow up and certify later by completing the Certification form and submitting it to you for signature and submission to PEBA. The effective date for the waiver (or premium if certifying as tobacco or e-cigarette user) will be the first of the month after PEBA receives the form.

If completing a paper *Notice of Election* (NOE), also complete and attach a *Certification Regarding Tobacco and E-cigarette Use* form before sending to PEBA for processing. The effective date for the waiver (or premium if certifying as tobacco or e-cigarette user) will be the effective date of coverage.

- If the Certification form is not attached to the NOE and is sent later, the effective date for the waiver (or premium if certifying as tobacco or e-cigarette user) will be the first of the month after PEBA receives the form.

If a change in status occurs that changes a subscriber's status for tobacco-use (i.e., a subscriber who does not use tobacco marries and enrolls his new spouse who does use tobacco), the subscriber must indicate the appropriate Tobacco and E-cigarette Use on the electronic enrollment or complete a new Certification form and submit to PEBA. The effective date for the premium will be the effective date of the coverage change.

Subscribers may apply to remove the premium once they and their covered spouse and/or child(ren) are tobacco- and e-cigarette-free for six months or if all covered individuals who use tobacco and/or e-cigarettes complete the Quit For Life smoking cessation program. They may certify by completing the Certification form and submitting it to you for signature and submission to PEBA. The premium will be removed the first of the month after PEBA receives the form.

Certification forms should not be held. They should be sent to PEBA immediately after being signed and dated.

MoneyPlus enrollment

MoneyPlus is offered to all full-time employees who are also eligible for health, dental and vision coverage, regardless of whether they are enrolled in coverage. This program, administered by ASIFlex, was designed in compliance with sections 105, 125, 129 and 223 of the Internal Revenue Code (IRC).

MoneyPlus offers five features: the Pretax Group Insurance Premium feature, the Medical Spending Account (MSA), the Dependent Care Spending Account (DCSA), the Health Savings Account (HSA), and the Limited-use MSA (LMSA). Participants in MSA, DCSA and LMSA accounts must re-enroll each year during open enrollment. Refer to the IBG for eligibility rules and information regarding these features.

If an employee has more than a 30-day break and is not considered a transfer or academic transfer, he will not be able to re-enroll in a MSA or DCSA until the next plan year.

Note: In 2021, the Dependent Care Spending Account (DCSA) is capped at $1,750 for highly compensated employees. However, the $1,750 cap is subject to adjustment in mid-year if PEBA's DCSA does not meet the *Average Benefit Test*. The test is designed to make sure highly compensated employees don't receive a benefit that is out of proportion to the benefit received by other employees. For 2021, the Internal Revenue Code defines a highly compensated employee as someone who earned $127,000 or more in calendar year 2020.

Effect of MoneyPlus on other retirement plans

State retirement plan

Contributions to or benefits from the retirement systems administered by PEBA are based on an employee's gross salary. Participation in MoneyPlus has no effect on pension contributions or benefits.

Deferred Compensation

Contributions to a Deferred Compensation account are based on an employee's net salary. Pretax dollars set aside for MoneyPlus elections are not included in income when determining the maximum that can be contributed to a Deferred Compensation account.

Social Security

Pretax dollars set aside for MoneyPlus elections are not subject to Social Security taxes. Therefore, there may be a slight reduction in future Social Security benefits.

Employees do not typically contribute to a DCSA for more than a few years, but employees may contribute to an MSA or HSA for many years, and the amounts contributed may vary significantly year to year.

Employees should consult their tax preparer or advisor to discuss their options.

If both spouses are eligible

- Each may participate in MoneyPlus, but there may be limitations/certain restrictions.
- Either spouse may claim an expense, but not both.

Effective dates for enrollment and changes

The effective dates for enrollment and changes in the Medical Spending Account (MSA) and Dependent Care Spending Account (DCSA) are the same as for health, dental and vision coverage for new hires; change in status effective dates will vary. Eligible employees have 31 days to enroll or to make changes due to a change in status.

Eligible employees may enroll in a MoneyPlus Health Savings Account (HSA) at any time. They may change their HSA elections on a monthly basis. HSA changes become effective the first of the month following the change.

Review MoneyPlus features

Pretax Group Insurance Premium

This feature allows employees to pay insurance premiums for health, dental, vision and up to $50,000 of Optional Life coverage before taxes. Once enrolled, the employee does not need to re-enroll each year.

Be sure to forward the election to your payroll office.

An employee does not have to participate in the Pretax Premium feature to participate in the spending accounts.

Medical Spending Account and Dependent Care Spending Account

Employees can take advantage of tax-favored accounts to save money on eligible medical and dependent care costs.

Provide a copy of the MoneyPlus flyers and refer the employee to www.ASIFlex.com/SCMoneyPlus. Note the monthly administrative fees.

- To participate in either account, the employee must enroll and elect an **annual** contribution amount.
- He must re-enroll each October to contribute the following year.
- The ASIFlex debit card is provided to MSA participants at no charge.
- Refer to the MoneyPlus COBRA section for employees who are retiring or otherwise terminating employment.

Limited-use Medical Spending Accounts are available to employees enrolled in the Savings Plan and a Health Savings Account. A Limited-use MSA will pay for expenses the Savings Plan does not cover, like dental and vision care.

Comptroller General agencies only

If your payroll is processed through the CG's office, complete a P-4 payroll change form and return it to the benefits office for all changes to existing deductions or additions of new deductions.

Medical Spending Account and Dependent Care Spending Account rules

Refer to the IBG for the eligibility information regarding these accounts.

- Participants may not be reimbursed twice for the same expense; an expense is not reimbursable if it is already covered under insurance or has been claimed through a spouse's flexible spending account.
- An employee has until December 31 to spend funds deposited in his MSA or Limited-use MSA during that year. An employee can carry over up to $550 of unused funds into the next plan year.
- An employee has until March 15 to spend any remaining funds deposited in his DCSA from January through December of the previous year.
- An employee has a 90-day *run-out period* (until March 31) to file claims for services incurred during the previous plan year.
- An employee will forfeit any unused funds in his MSA or Limited-use MSA over the $550 carryover amount not claimed by March 31.
- An employee will forfeit any unused funds in his DCSA not claimed by March 31. These funds cannot be returned to the employee or carried forward to a new plan year.
- ASIFlex provides easy access to account statements online or via the mobile app. In addition, account information is provided with each reimbursement.
- PEBA, at its discretion, may elect to send statements to participants who have an available balance. The statements are sent based on participant preference of email/text alert or USPS mail, and not more frequently than quarterly.
- ASIFlex includes a reminder of the 90-day run-out period in the statements.

Medical Spending Accounts only

Generally, the expense must be incurred prior to reimbursement. Incurred means that the service or supply has been provided that gives rise to the expense, regardless when paid or billed.

If the employee has an ASIFlex debit card, ASI will auto-adjudicate debit card transactions it can match to claims received from other vendors. If ASIFlex cannot validate a claim, the employee will need to provide documentation for that transaction. The account must be reimbursed for any ineligible expenses that were paid with the card.

- Requests for documentation are emailed and posted online to the employee's ASIFlex account. The employee will have 52 days to respond or the card will be deactivated. The employee will receive three notices before the card is deactivated.
- When documentation is submitted, the employee's card will be automatically reinstated.

If the employee does not have or use the ASIFlex debit card, he will need to submit a claim online or via the ASIFlex mobile app. The employee may also submit a paper claim form, along with any pertinent documentation.

Any debit card transactions not cleared by March 31 after the plan year ends are in violation of IRS guidelines and may be taxable as income. In this situation, the transactions will be reclassified by the employer and may need to be included on next year's W-2 as income.

Orthodontia

There are special rules regarding orthodontia:

- The initial service (banding) must have occurred before reimbursements may begin.
- A contract payment agreement from your orthodontist can be provided with your

claim, and you can be reimbursed as payments are made based on the agreement. You must also provide proof of payment and reimbursement is made from the plan year in which the payment is made.

Whose expenses are eligible under an MSA?

- Employee;
- Employee's spouse;
- Employee's qualifying child; or
- Employee's qualifying relative.

An individual is a **qualifying child** if he is not someone else's qualifying child, and:

- Is a U.S. citizen, national or resident of the U.S., Mexico or Canada;
- Has a specified family-type relationship to the employee: son/daughter, stepson/stepdaughter, eligible foster child, legally adopted child, or child placed for legal adoption;
- Lives in the employee's household for more than half of the tax year;
- Does not reach age 27 during the taxable year; and
- Has not provided more than half of his own support during the tax year.

An individual is a **qualifying relative,** if he is a U.S. citizen, national or resident of the U.S., Mexico or Canada, and:

- Has a specified family-type relationship to the employee, is not someone else's qualifying child and receives more than half of his support from the employee during the tax year, or
- If no specified family-type relationship to the employee exists, is a member of, and lives in, the employee's household (without violating local law) for the entire tax year and receives more than half of his support from the employee during the tax year.
- "Qualifying relative" is a federal term and has no bearing on whether you can cover that person as a dependent under the state insurance benefits.

Note: There is no age requirement for a qualifying child if he is physically and/or mentally incapable of self-care. An eligible child of divorced parents is treated as a child of both, so either or both parents can have an MSA.

Dependent Care Spending Accounts only

Sufficient funds must be available for eligible expenses to be reimbursed.

- Funds are posted to participants' accounts upon processing of MoneyPlus payrolls.

Claims for which there are insufficient funds will be held and processed as the funds become available; the employee should not need to refile.

The expense (or period of service, such as a month's worth of daycare) must be incurred prior to reimbursement.

Whose expenses are eligible under a DCSA?

The employee may use his DCSA to receive reimbursement for eligible dependent care expenses for qualifying individuals. A qualifying individual includes a **qualifying child** if the child:

- Is younger than 13 or is physically or mentally incapable of self-care;
- Is not someone else's qualifying child;
- Is a U.S. citizen, national or resident of the U.S., Mexico or Canada;
- Has a specified family-type relationship to the employee; and
- Spends at least eight hours per day in the employee's home.

A qualifying individual includes the employee's **spouse** if the spouse:

- Is physically and/or mentally incapable of self-care;
- Lives in the employee's household for more than half of the tax year; and
- Spends at least eight hours per day in the employee's home.

A qualifying individual includes the employee's **qualifying relative** if the relative:

- Is a U.S. citizen, national or resident of the U.S., Mexico or Canada;
- Is physically and/or mentally incapable of self-care;
- Is not someone else's qualifying child;
- Lives in the employee's household for more than half of the tax year;
- Spends at least eight hours per day in the employee's home; and
- Receives more than half of his support from the employee during the tax year.

Note: If the employee is the tax dependent of another person, he cannot claim DCSA expenses for other qualified individuals. The employee cannot claim a qualifying individual if that individual files a joint tax return with a spouse. If the parents of a child are divorced or legally separated, only the custodial parent can be reimbursed for child care through the DCSA.

Health Savings Account

The Savings Plan goes hand in hand with a Health Savings Account, or HSA, which pays for future out-of-pocket medical expenses.

Provide a copy of the *Health Savings Account* flyer. Note the monthly administrative fees and Central Bank fees.

To participate, the employee must enroll in the Savings Plan. The employee must also open a bank account with Central Bank, and provide a validation code from Central Bank to complete the enrollment transaction.

The benefits administrator can add the validation code from Central Bank for the employee, if necessary. The employee will need to open a bank account with Central Bank, and either provide you with the validation code or a copy of the Central Bank confirmation page.

For PEBA to approve the transaction, the confirmation code must be provided on the coverage screen or a copy of the Central Bank confirmation page must be submitted as supporting documentation. If the information is not provided, PEBA will reject the transaction.

Central Bank charges HSA participants a monthly maintenance fee of $1.25 for balances less than $2,500, and it will be automatically deducted from the account.

Comptroller General agencies only

If your payroll is processed through the CG's office, complete a P-4 payroll change form and return it to the benefits office for all changes to existing deductions or additions of new deductions.

Health Savings Account rules

If both spouses contribute to an HSA, and one of them has family coverage (employee/spouse, employee/children or full family coverage), their combined HSA contributions cannot exceed the IRS-allowed limit for family coverage. If both spouses have employee-only coverage, each may contribute up to the IRS-allowed limit for single coverage.

Expenses are reimbursable only if there are sufficient funds in the account. Participants may use their HSA debit cards (Central Bank) to get funds directly out of their accounts for eligible expenses. Reimbursements are not requested through ASIFlex.

Participants may not be reimbursed twice for the same expense. An expense is not reimbursable if it is already covered under insurance. Participants are solely responsible for maintaining proper documentation and providing it to the IRS if requested.

Central Bank provides monthly statements online to participants.

By IRS regulations, amounts not claimed after the year's end may be carried forward to subsequent tax years.

An employee may defer reimbursements, until later tax years, so long as the eligible expenses were incurred after the HSA was established and the

employee is keeping sufficient records to document the eligible expenses.

Participants will receive tax reports from Central Bank to use for tax filing purposes.

GEA TRICARE Supplement Plan enrollment

When enrolling an employee in the GEA TRICARE Supplement Plan, submit a copy of the employee's TRICARE Card with the enrollment.

- PEBA will process the enrollment and send information to Selman & Company.
- Selman & Company will verify the employee's eligibility with the Defense Enrollment Eligibility Reporting System (DEERS).
- If the employee is eligible, Selman & Company will send him a GEA TRICARE Supplement Plan enrollment packet.

The monthly premium includes a minimal administrative fee for the processing of premium payment which may appear as a discrepancy between Selman & Company's billing statement and subscriber's payroll deducted amount.

Assisting a newly eligible variable-hour, part-time or seasonal employee

New variable-hour, part-time or seasonal employees are not offered benefits when they are first hired. Instead, the employer must measure the employee's hours over an initial 12-month measurement period to determine whether the employee will be eligible for benefits.

A new variable-hour, part-time or seasonal employee credited with an average of 30 hours per week during his Initial Measurement Period may enroll during an Initial Administrative Period, which begins the day after the end of his Initial Measurement Period and ends the last day of the same calendar month. Once an employer deems an employee eligible for benefits, the employee remains eligible for 12 months during his Initial Stability Period regardless of the number of hours the employee works.

Example: An employee hired on December 5, 2021, would not have been employed for the entire Standard Measurement Period (October 4, 2021-October 3, 2022); therefore, the employee will have his own Initial Measurement Period, Administrative Period and Stability Period:

- Initial Measurement Period: January 1, 2022-December 31, 2022
- Initial Administrative Period: January 1, 2023-January 31, 2023
- Initial Stability Period: February 1, 2023-January 31, 2024

During the Administrative Period, the employer would review the hours worked by the employee during his Initial Measurement Period. If the employee is deemed eligible for benefits, the employer would offer coverage and complete the enrollment by January 31, 2023 If the employee was deemed eligible for benefits, he would remain eligible for the duration of his Stability Period, regardless of the number of hours he works.

In accordance with the ACA and as defined in paragraphs 3.23 of the *Plan of Benefits* document, variable-hour, part-time and seasonal employees who are eligible for benefits are eligible for all benefits.

Eligible employees must elect or refuse coverage within the employee's designated Administrative Period. Coverage is effective the first of the month after the end of the Administrative Period. Employees enrolling in a health plan must also certify their tobacco use.

The employee is allowed to change his mind about an original selection within the Administrative Period. To make a new selection, a paper *Notice of Election* must be signed within the 31-day window and submitted to PEBA for processing as a revision.

Completing the enrollment

The same procedures apply for completing the enrollment of an active subscriber (see Pages 16-19) with the following exception:

STATUS: Employer should select the category for the type of employee who is enrolling in coverage.

- While variable-hour, part-time and seasonal employees are eligible for active employee benefits, they are not automatically eligible for retiree coverage if they retire from a nonpermanent position. See the Retiree section beginning on Page 85 for retiree eligibility requirements, including that the last five years of active employment must be full-time, permanent and consecutive.

Assisting a permanent, part-time teacher

As defined in S.C. Code Ann. §59-25-45 and in paragraph 2.53 of the Plan of Benefits document, permanent, part-time teachers of S.C. public schools, the S.C. Department of Corrections, the S.C. Department of Juvenile Justice and the S.C. School for the Deaf and Blind may be eligible for:

- Health (State Health Plan and GEA TRICARE Supplement Plan).
- Dental Plus and Basic Dental.
- State Vision Plan.
- MoneyPlus.

Permanent, part-time teachers are ***not*** eligible for:

- Basic Life insurance.
- Optional Life insurance.
- Dependent Life insurance for children or spouses.
- Basic Long Term Disability.
- Supplemental Long Term Disability.

The employee must be in a contract position and receive an EIA (Education Improvement Act of 1984) salary supplement. In addition to classroom teachers, this may also include other academic personnel, such as librarian/media specialists, guidance counselors, ROTC (Reserve Officer Training Corps) instructors, school nurses, social workers, psychologists, audiologists or other instructional staff. Contact the Department of Education at 803.734.8122 for additional information pertaining to the specific law or determining eligibility of a position.

The employee must work at least 15 hours per week, but fewer than 30 hours per week.

- There are three part-time categories based on the number of hours worked per week (Category I = 15-19 hours; Category II = 20-24 hours; Category III = 25-29 hours). Premiums are based on the applicable category.

An employee who is eligible as a permanent, part-time teacher and also eligible as a spouse under a covered spouse's file, may elect coverage as a permanent, part-time teacher or as spouse, but not both. A permanent, part-time teacher with health, dental and/or vision coverage as a subscriber cannot be covered on the spouse's plan under any benefit (health, dental, vision or Dependent Life).

- If the employee wants to remain on his spouse's coverage, complete an *Active Part-time Teachers NOE* refusing all coverage and send it to PEBA.

While permanent, part-time teachers are eligible for active employee benefits under § 59-25-45, they are not automatically eligible for retiree coverage if they retire from a part-time teacher position. See the Retiree section beginning on Page 85 for retiree eligibility requirements, including that the last five years of active employment must be full-time and continuous.

Eligible employees must enroll within 31 days of date of hire by enrolling through EBS/MyBenefits or by completing an *Active Part-time Teachers NOE*.

Effective dates of coverage are the same as for other new hires. The 31-day window for elections

and changing elections is also the same as for other new hires.

Employees enrolling in a health plan must also certify their tobacco use.

Completing the enrollment

When completing the permanent *Part-Time Notice of Election*, select one category based on the number of hours worked each week. The benefits administrator should confirm the accuracy of the selection.

Process for medical emergencies

If a subscriber has a medical emergency and an enrollment or change needs to be processed the same day, complete the transaction in EBS. A BIN will be generated immediately. See Section B, Using the Online Enrollment System, for more information.

- If you are unable to get the employee's signature on the SOC or SOE, include a copy of the signed *Notice of Election* form. After the transaction is complete and you have uploaded the documentation required, if any, call PEBA's BA Contact Center.
- If the subscriber's file is in suspense because of a rejection, call PEBA's BA Contact Center. The call center representative will delete the suspended transaction so that you can complete the transaction in EBS. After the transaction has been approved, the call center representative will release it and update the third-party claims processors.

A subscriber can obtain medical services before he has an insurance card by giving his member ID to his provider.

- If the subscriber is enrolled, his member ID is ZCS followed by his BIN.
- If the subscriber is enrolled in the GEA TRICARE Supplement Plan, his member ID is PC followed by his BIN.

A subscriber can obtain prescription drugs before he has an insurance card.

- State Health Plan subscribers can tell the pharmacist they are with Express Scripts. The pharmacist may need only the member's name and his eight-digit claim. If the pharmacist needs more information from the card:
- **All active employees and their covered dependents** should provide:
    - RxGroup: SCPEBAX;
    - RxPCN: A4; and
    - RxBIN: 003858.
- **Retirees not enrolled in Medicare** should provide:
    - RxGroup: SCPEBAX;
    - RxPCN: A4; and
    - RxBIN: 003858.
- **Retirees enrolled in Medicare** should provide:
    - RxGroup: 7258MDRX;
    - RxPCN: MEDDPRIME; and
    - RXBIN 610014.

National Medical Support Notices

National Medical Support Notices (NMSNs) are forms sent to employers when an employee is under an existing court or administrative order to provide insurance for his child(ren). Timely completion helps ensure children have the required coverage.

If you receive an NMSN, email it to PEBA at medicalsupportnotices@peba.sc.gov as soon as possible. The format of the notice may vary, but it will always say National Medical Support Notice at the top of the first page, and it will have sections labeled Employer Response and Plan Administrator Response.

- Complete **only** the Employer Response section and return it to the issuing child support agency before you send a copy to PEBA.
- You do not have to complete an NOE.
- Please note, the information on the custodial parent and child(ren) contained on the NMSN should not be shared with the employee. Additionally, the NMSN should not be placed in the employee's file unless identifying information for the child and custodial parent has been redacted. If the employee has questions concerning the coverage requirements and plan choice, please refer the employee to the issuing agency.
- PEBA will complete the Plan Administrator Response and send it to the issuing agency. PEBA will also complete any extra forms or questionnaires about health insurance that might be included. You will be notified if election changes are made.

NOTE: Special eligibility situation rules do not apply to NMSNs. Subscribers may not make changes to their benefits other than those specified in the NMSN, which PEBA will determine. Subscribers are not allowed to make coverage changes through MyBenefits.

Compliance with the NMSN is mandatory under federal law. PEBA **cannot** discontinue coverage until the issuing agency sends an updated NMSN or other order.

When an employee who is covering a child under an NMSN leaves employment, send a COBRA notice for the child to the custodial parent listed on the NMSN.

Rules and procedures for late entrants

Health plans

- The employee must wait until the next October enrollment period to enroll as a late entrant or to add a spouse or child(ren) as a late entrant. Someone who enrolls due to a special eligibility situation is not considered a late entrant.
- No medical evidence of good health is required for subscribers, their spouses or children.
- There are no pre-existing condition exclusions under any of the health plans offered through PEBA.

Dental

- The employee must wait until the next open enrollment period of an odd-numbered year to enroll as a late entrant or to add a spouse or child(ren) as a late entrant.
- There is no dental underwriting for subscribers, their spouses or children.
- There are no pre-existing condition exclusions under Dental Plus or Basic Dental.

Vision care

(Group number 9925991)

- The employee must wait until the next October enrollment period or special eligibility situation to enroll in the State Vision Plan as a late entrant or to add a spouse or child(ren) as a late entrant.
- There is no medical evidence of good health for subscribers, their spouses or children.
- There are no pre-existing condition exclusions under the State Vision Plan.

Life insurance

Optional Life

(Policy number 200879)

- If they do not participate in the MoneyPlus pretax premium feature, eligible participants may enroll in Optional Life or increase coverage throughout the year.
- Late entrants must provide evidence of insurability and be approved.
- If they do participate in the MoneyPlus pretax premium feature, eligible participants may enroll in Optional Life or increase coverage only during announced enrollment periods or within 31 days of a special eligibility situation.
- Late entrants must provide evidence of insurability and be approved.

Refer to Page 50 for the procedures for adding and changing Optional Life insurance coverage outside of a new hire situation.

Dependent Life-Spouse

(Policy number 200879)

- Eligible spouses may be added throughout the year.
- Evidence of insurability is required for spouses enrolled as late entrants.

Refer to Page 53 for the procedures for adding and increasing Dependent Life insurance coverage with medical evidence.

Dependent Life-Child

(Policy number 200879)

- Eligible dependent children may be added throughout the year.
- No evidence of insurability is required for children enrolled as late entrants.

Supplemental Long Term Disability

(Policy number 621144A)

- Have the employee complete the *Medical History Statement for Late Entrants and Instructions*.
- Send the completed original to Standard Insurance Company.
- When an approval is received from The Standard, have the employee complete a paper *Notice of Election* to select the coverage for which he was approved. This may be done earlier and held for approval from The Standard.
- Send the approval from The Standard with the paper NOE to PEBA.
- Premiums start with the effective date of coverage (first of the month after approval).

Changes in status and special eligibility situations

(Health, Dental Plus/Basic Dental, State Vision Plan, Dependent Life, MoneyPlus)

Enrollment changes must be requested within 31 days of the changes in status that follow, and any supporting documentation must be submitted. Changes not made within 31 days of the event cannot be made until the next open enrollment period or until another change in status or special eligibility situation occurs.

If the change in status or special eligibility situation changes the tobacco-use status, the subscriber must indicate the appropriate Tobacco Coverage on the paperless enrollment or complete a new Certification form and submit to PEBA with the NOE. The effective date for the premium will be the effective date of the coverage change on enrollment.

More information on changes related to a spouse or child(ren) can be found on Page 99.

Gain of other group coverage

Effective date to drop PEBA coverage: First of the month after gaining other coverage or the first of the month if coverage is gained on the first of the month. See exceptions for gaining Medicare and Medicaid effective dates below.

An exception to the 31-day rule exists when a spouse who gains coverage or becomes eligible for coverage *as a subscriber of a participating employer* must be dropped from the employee's coverage. If the employee fails to drop the ineligible spouse within 31 days, the spouse may be dropped retroactively to coincide with the date the spouse was added to coverage at the other participating employer.

An employee may terminate health, dental and/or vision coverage if he gains other group coverage. He can drop only the type of coverage he gained.

An employee may drop a spouse or child(ren) from coverage if his spouse or child(ren) gains other group coverage. Only the spouse or children who gained other coverage may be dropped. The spouse or child(ren) can be dropped only from the type of coverage he gained.

- However, if the spouse is gaining coverage as an employee of a *participating employer*, the subscriber must drop the spouse within 31 days; he cannot wait until the open enrollment period.
- If a spouse or child(ren) gains eligibility for coverage and attempts to enroll as an employee of a *participating employer*, PEBA will reject the enrollment, because the spouse or child(ren) must be terminated from the other coverage first.

A gain of other group coverage notice is required only if the group is **not** participating with PEBA insurance benefits. The notice must be submitted in EBS or attached to the NOE.

- The gain of coverage notice must include the effective date of coverage, the type(s) of coverage (health, dental and/or vision) and list all individuals who gained coverage.
- The notice must state gained health coverage to change coverage level or drop health coverage; it must state gained dental coverage to drop dental coverage; it must state gained vision coverage to drop vision coverage. *Exception*: Medicaid includes health, dental and limited vision coverage (for children only) automatically.

If the group is participating with PEBA insurance benefits, write *Gained State Coverage* at the top of the NOE.

If the subscriber has not received the gain of coverage notice, and the deadline to enroll in PEBA coverage is nearing, complete the transaction in EBS or submit the NOE without the letter. Submit the letter as soon as it is available. Changes will not be processed until all documents have been received.

Gain of Medicare coverage

Effective date to drop PEBA coverage: First of the month after the gain of Medicare or the first of the month if Medicare is gained on the first of the month. If the effective dates of Part A and Part B are different, the subscriber can make a change in coverage through PEBA only within 31 days of the confirmation letter from the Social Security Administration. The letter is typically sent when the subscriber becomes eligible for Part A.

An employee may terminate health coverage if he gains Medicare.

An employee may drop a spouse or child from health coverage if his spouse or child gains Medicare. Only the spouse or children who gained Medicare may be dropped.

A copy of the Medicare card, verifying gain of Medicare coverage, must be attached to the NOE.

Note on Medicare Part B and Medicare Part D: Most **active** employees who become eligible for Medicare at age 65 should delay enrolling in Medicare Part B, because their coverage through PEBA remains

primary while they are working. Likewise, most active employees should not sign up for a separate Medicare Part D plan, because their prescription drug expenses will continue to be covered through their plan with PEBA. If an active employee signs up for Part D, PEBA will *not* be able to drop his prescription drug coverage.

There are exceptions for employees who become eligible for Medicare due to disability or end-stage renal disease. Refer to the IBG or call PEBA's Customer Contact Center for more information.

When an individual begins dialysis for end-stage renal disease, he becomes eligible for Medicare typically three months after beginning dialysis. At this point, he begins a coordination period of 30 months. During this time, his coverage through the State Health Plan remains primary. When the coordination period ends, Medicare becomes primary. The coordination period applies whether the subscriber is an active employee, a retiree, a survivor or a covered spouse or child, and regardless of whether the subscriber was already eligible for Medicare due to another reason, such as age. If the subscriber was covered by the Medicare Supplemental Plan, he will be changed to the Standard Plan during the 30-month coordination period.

Gain of Medicaid coverage

Effective date to drop PEBA coverage: Effective date of the Medicaid coverage.

Exceptions to the 31-day rule: If the subscriber and his covered family members become eligible for Medicaid or the Children's Health Insurance Program (CHIP), the subscriber has 60 days from the date of notification to drop coverage through PEBA. If the Medicaid effective date is retroactive more than 60 days before the date of notification, then the effective date will be the first of the month after the request. If the subscriber notifies PEBA more than 60 days after he was notified by Medicaid, no changes are allowed.

An employee may terminate health, dental and/or vision coverage if he gains Medicaid.

An employee may drop a spouse or child(ren) from coverage if his spouse or child(ren) gains Medicaid. Only the spouse or children who gained Medicaid may be dropped.

A copy of the Medicaid approval letter must be attached to the NOE or submitted in EBS.

Medicaid coverage includes health, dental and vision coverage. The vision coverage includes an annual eye exam and a pair of glasses following cataract surgery. Vision coverage for children younger than age 21 includes one eye exam and one pair of glasses once a year. For most adults 21 and older, this dental coverage includes emergency services only, such as extractions or treatment for acute infections. Dental coverage for children younger than age 21 includes basic coverage with preventive services. For more information on Medicaid coverage, contact DHHS (contact information will be on the Medicaid approval letter).

Loss of other group coverage

(Includes Medicare and Medicaid)

Effective date: The date of the loss of coverage.

Exceptions to the 31-day rule: If the subscriber and his covered family members lost coverage through Medicaid or the Children's Health Insurance Program (CHIP), the subscriber has 60 days to enroll in coverage through PEBA.

If the subscriber loses other health coverage, and he is not already enrolled in health through PEBA, he can enroll himself, his spouse and his children in health, Dental Plus or Basic Dental and vision. The subscriber must enroll in coverage he is adding for his spouse or children. He cannot drop or change his current coverage.

If the subscriber is already enrolled in health through PEBA, he cannot make changes.

If the subscriber loses other dental coverage, he can enroll in Dental Plus or Basic Dental.

If the subscriber loses other vision coverage, he can enroll in vision.

If the subscriber's spouse or child(ren) loses other health coverage, he can enroll himself and the spouse or child(ren) who lost coverage in health, Dental Plus or Basic Dental and vision. The subscriber must enroll in coverage he is adding for his spouse or children. If the subscriber is already enrolled in health, he may change plans if he adds the spouse or child who lost coverage. He cannot drop his current coverage.

If the subscriber's spouse or child(ren) loses other dental coverage, he can enroll himself and the spouse or child(ren) who lost coverage in Dental Plus or Basic Dental. The subscriber must enroll in coverage he is adding for his spouse or children.

If the subscriber's spouse or child(ren) loses other vision coverage, he can enroll himself and the spouse or child(ren) who lost coverage in vision. The subscriber must enroll in coverage he is adding for his spouse or children.

If the subscriber's spouse loses other life insurance coverage, it is not a special eligibility situation. However, the subscriber may add the spouse to Dependent Life with evidence of insurability throughout the year. If the subscriber's spouse loses life insurance coverage as an employee of a PEBA insurance benefits-participating employer, the spouse may be added to Dependent Life ($10,000 or $20,000 in coverage) without evidence of insurability.

Documentation of dependent eligibility should be attached to the NOE or submitted in EBS.

- A marriage license or Page 1 of the employee's latest federal tax return if filing jointly is required to add a spouse.
- A long-form birth certificate showing the subscriber as the parent is required to add a child.
- A long-form birth certificate and marriage license naming spouse as parent is required to add a stepchild. Return the completed form to PEBA.

Documentation of loss of coverage should be uploaded in EBS or attached to the NOE.
Acceptable documentation is a creditable coverage letter or a notice that includes the effective date of the loss of coverage, the type of coverage lost (health, dental and/or vision), and the names of all individuals who lost coverage.

- If the coverage that was lost was through a *participating employer*, write *Lost State Coverage* at the top of the NOE. This will alert PEBA staff to access the previous coverage data on the individual.
- If the subscriber loses other health coverage, and he is not already enrolled in health through PEBA, his spouse and children can be added to health, Dental Plus, Basic Dental and vision even if they are not listed on the loss of coverage letter. The letter does not need to state subscriber lost dental or vision for him to enroll in those coverages.
- If the subscriber's spouse or child(ren) loses other health coverage, the loss of coverage letter does not need to say spouse or child(ren) lost dental or vision for the spouse or child(ren) to enroll in Dental Plus or Basic Dental and vision.

If the subscriber has not received the loss of coverage letter, and the deadline to enroll in PEBA coverage is nearing, complete the transaction in EBS or submit the NOE without the letter. Submit the letter as soon as it is available. Changes will not be processed until all documents have been received. The effective date will remain the date of loss of other coverage.

Note about premiums
If the employee is enrolled in the MoneyPlus Pretax Group Insurance Premium feature, premiums must be paid post-tax for retroactive coverage back to

the date of loss of coverage. Premiums may be paid pretax beginning the first of the month following the date of the request.

Loss of TRICARE coverage

Effective date to drop PEBA coverage: First of the month after a subscriber or dependent is no longer eligible for TRICARE, if enrolled in the TRICARE Supplement.

Selman & Company provides employers with monthly eligibility reports. If a subscriber or dependent is no longer eligible for TRICARE, submit a paper NOE and a copy of the report from Selman & Company to PEBA to cancel coverage.

- Strike through any information that doesn't apply to that specific subscriber or dependent.
- If the report lists more than one subscriber or dependent who lost eligibility, attach a copy of the report to each NOE.

MoneyPlus change in status rules

The rules and effective dates for changes in status are similar to those for health insurance. There are some additional changes that are allowed by the IRS. Refer to the *Flexible Benefits Plan* document for these allowed changes. For example, a child turning age 13, who is no longer eligible for dependent care, is an allowed change in status event for Dependent Care Spending Accounts.

Eligible employees have 31 days to enroll or to make a change when a qualifying change in status occurs. The payroll adjustment must coincide with the effective date of the change in status.

Changes/new elections must be consistent with a qualifying family status change. For example, decreasing your Medical Spending Account contributions when your adult child gets a job and coverage elsewhere is consistent with the gain of other coverage; increasing your contributions is not.

- **Pretax Group Insurance Premium feature:** If the employee is eligible to change health, dental, vision or Optional Life coverage due to a change in status, he may also enroll in or drop his Pretax Group Insurance Premium feature.
- **Dependent Care Spending Account:** If a DCSA is terminated, the employee can continue to submit claims, while employed, until the end of the year or until the account is exhausted .
- **Medical Spending Account:** If an MSA is terminated, the employee can submit expenses incurred only through the date of termination.
- **Health Savings Account:** Change in status rules do not apply to HSAs. HSA contributions may be started at any time and stopped or changed monthly, regardless of the situation.

Refer to the Transfers and Terminations section and the COBRA section of this manual for more information on continuation of MSA and HSA accounts at termination.

Completing the enrollment for a change in status

Use EBS when an employee wants to change his MoneyPlus account(s) due to a change in status.

Select MoneyPlus as the Reason for Change and select the Sub-Reason from the drop-down list. Enter the date of the event, not the effective date of the change. Complete the enrollment change(s) and apply to MyBenefits or Current EBS.

Note that certain changes are not allowed due to the defined change reason.

Deductions for any accounts which the employee has but does not wish to change as a result of the change in status, will remain the same.

If completing the enrollment change(s) on a paper *Notice of Election* form, follow the NOE instructions and check and date all qualified change events for

MSA and DCSA accounts, then return the completed form to PEBA.

If PEBA does not receive the enrollment change before the participant submits claims related to the change in status, those claims may be rejected. If ASIFlex does not receive adjusted payroll data that matches the payroll effective date or payroll amount on the form, related claims may be rejected.

Coverage changes for permanent, part-time teachers

(Health, dental and vision)

The policies and procedures regarding health, dental and vision changes for active subscribers also apply to permanent, part-time teachers.

Increase or decrease in the number of contract hours

If the increase or decrease in an employee's contracted work hours causes a change in status (i.e., from 15 to 25 hours per week, etc.):

- Submit a new NOE, reflecting the change in status.
- If this is a temporary change, you do not have to notify PEBA, and no changes should be made.
- If an increase in hours makes the employee eligible as a permanent, part-time teacher:
- The date of hire will be the date of the contract change.
- The effective date will be the first of the month after the date of the contract change (or the first working day of the month, if applicable).

If an employee's work hours are contractually reduced to fewer than 15 hours per week:

- Complete the termination in EBS, or submit an *Active Termination Form* to PEBA. Check the T5 box, Not Eligible (Not in a Stability Period.) In EBS, choose Left Employment. Change is effective the first of the month after the work hours are reduced.

The employee may make new health and dental selections based on an increase or decrease in hours.

- If the decrease in hours places the employee in a lower category (e.g., he enrolled in Category III working 26 hours and the contract changes to 23 hours), he may decrease or increase his coverage.
- If the increase in hours places the employee in a higher category (e.g., he enrolled in Category I working 17 hours and the contract changes to 23 hours), he may select and/or increase his benefits.
- If the increase in hours reaches 30 hours per week, classifying him as a permanent, full-time employee, he is eligible to make all new selections. Treat him as a new hire and offer all benefits to him, effective the first of the month after he reaches permanent, full-time status.

Other coverage changes

Optional Life

To determine the allowable timeline for changes to Optional Life coverage, review whether the employee participates in the MoneyPlus Pretax Group Insurance Premium feature.

Not participating in MoneyPlus

The 31-day rule does not apply if a subscriber is **not** participating in the MoneyPlus Pretax Premium feature. Subscribers **not** participating in the Pretax Premium feature may:

1. Add or increase coverage at any time during the year by providing medical evidence, with approval from MetLife:
   - Complete a *Statement of Health* form and submit it to MetLife for review. If additional information or medical data is needed, MetLife will send a letter to the subscriber.

- MetLife allows 60 days to respond. A reminder letter is sent if no response is received within 31 days. If no response is received in another 31 days, the file is closed.
- MetLife subcontracts for a paramedical exam, if an exam is necessary to make a determination. If required, this step also follows the same 31- and 60-day process.

Once MetLife receives all needed information, a decision will be made within 10 business days. MetLife mails a Notification Statement to the subscriber and emails the benefits administrator.

Submit the change in EBS by selecting Optional Life Changes – Not a MoneyPlus participant as the Reason for Change and select the Sub-Reason from the drop-down list. Enter the approval date from MetLife. Complete the enrollment change(s) and apply to MyBenefits or Current EBS. A copy of the MetLife approval is required as supporting documentation.

If submitting on a *Notice of Election* form, forward a copy of the weekly Statement of Health Report from MetLife and the NOE that shows the increase in coverage to PEBA so the subscriber's file can be updated and the billing statement adjusted.

The effective date will be the first of the month after approval from MetLife.

2. Add or increase coverage, without medical evidence, due to a special eligibility situation:
   - The change must be made within 31 days of the special eligibility situation (marriage, divorce, birth, adoption or placement for adoption).
   - The effective date of the change will be the first of the month after the change is requested.
   - If the subscriber refused Optional Life as a new hire, he may add coverage, up to $50,000 (in increments of $10,000). If the subscriber is already enrolled in Optional Life, he may increase coverage, up to an additional $50,000 (in increments of $10,000 and not to exceed the maximum amount allowed).
3. Decrease coverage: Effective the first of the month after the change is requested.
4. Cancel coverage: Effective the first of the month after the change is requested.

Participating in MoneyPlus

Changes must be made within 31 days of the special eligibility situation or the employee must wait until the next enrollment period. Subscribers participating in the Pretax Premium feature may:

1. Add coverage. The Optional Life request must be consistent with the special eligibility situation. If the subscriber refused Optional Life as a new hire, he may:
   - Add coverage, up to $50,000 (in increments of $10,000), without medical evidence. The effective date of the change will be the first of the month after the change is requested.
   - Add coverage, more than $50,000 (in increments of $10,000 and not to exceed the maximum amount allowed), with medical evidence. Complete a *Statement of Health* form and submit it to MetLife for review.

   Complete the special eligibility enrollment in EBS, requesting the level for which the employee is eligible without medical evidence ($50,000), effective the date of the event. Complete the NOE for the *total amount* of coverage (with medical evidence) and hold until approval is received from MetLife.

   Once approved, send the NOE, with the weekly Statement of Health Report from MetLife, to PEBA.

   The effective date will be the first of the month after approval from MetLife.

2. Increase coverage, up to an additional $50,000, without medical evidence.

The effective date will be the first of the month after the change is requested.

3. Increase coverage, more than $50,000, with medical evidence.

   Complete the special eligibility enrollment in EBS, requesting the level for which the employee is eligible without medical evidence ($50,000), effective the date of the event. Complete the NOE for the *total amount* of coverage (with medical evidence) and hold until approval is received from MetLife.

   Once approved, send the NOE, with the weekly Statement of Health Report from MetLife, to PEBA.

4. Decrease coverage. The Optional Life request must be consistent with the special eligibility situation. The effective date will be the first of the month after the change is requested. *Exception*: The effective date for the death of a spouse will be the day after death, as with other benefits.

5. Cancel coverage. The Optional Life request must be consistent with the special eligibility situation. The effective date will be the first of the month after the change is requested. *Exception*: The effective date for the death of a spouse will be the day after death, as with other benefits.

Effective date note: If the employee is not *actively at work* (the employee is absent from work due to a physical or mental condition, including absence due to maternity/birth) on the date his Optional Life selection becomes effective (add Optional Life coverage or increase in the level of Optional Life), the effective date will be the first of the month after the employee returns to work for one full day. The "Actively at Work" requirement is defined in the IBG's Life insurance chapter.

If request for additional coverage is denied

If MetLife denies additional coverage, based on evidence of insurability:

- The employee may request from MetLife, in writing, additional information regarding the denial.
- Do not forward the NOE or denials to PEBA.
- If denied, the employee may reapply by submitting a new *Statement of Health* form.

Dependent Life

Dependent Life-Child

- If there is only one child on coverage, terminate the coverage in EBS.
- Other changes **must** be made on an NOE, dated and signed by the subscriber and the benefits administrator. *Exception:* Newborns are automatically covered for 31 days from live birth. To continue coverage, add the newborn via EBS within 31 days or submit a request for review in EBS if it's after the 31-day window.
- Coverage may be canceled upon request, effective the first of the month after the request is made (or up to 12 months retroactively if dropping the last eligible child due to death or if the system terminates the last eligible child).
- Certification of student status or incapacitation is required for ages 19-24 to be covered. No death claims will be paid without this documentation.
- Coverage may be added throughout the year, effective the first of the month after the request. *Exception:* Legal custody/guardianship is not considered a special eligibility situation for enrolling a child in Dependent Life-Child coverage or for the subscriber to enroll himself or increase his Optional Life coverage. The child must be legally adopted or placed for adoption to make these changes.
- If the request is made within 31 days of birth or the date you acquired the child, coverage will become effective the date of the event.
- The Dependent Non-confinement Provision for spouses and children, explained in the

IBG and below, will apply, *except for newborns.*

Dependent Life-Spouse

- Coverage up to $20,000 may be added within 31 days of date of marriage, birth, adoption or within 31 days of loss of other coverage with a participating employer, without providing evidence of insurability.
- Coverage may be added, increased, decreased or canceled throughout the year.
- Evidence of insurability is required for late entry and to increase Dependent Life-Spouse coverage beyond $20,000, up to the maximum allowed.

- Medical evidence procedures:
- Complete an NOE, listing the spouse to be added to coverage or to have coverage increased.
- Complete a *Statement of Health* form and submit it to MetLife for review. Keep a copy to hold in the pending file.
- Once approved, send the NOE along with the weekly Statement of Health Report from MetLife and the copy of the *Statement of Health* form to PEBA.
- MetLife will notify the subscriber of the approval/denial.
- The effective date will be the first of the month after approval from MetLife.

Effective date note: Under the Dependent Non-confinement Provision, if a spouse or child (other than a newborn) is confined to a hospital or elsewhere due to a physical or mental condition on the date his Dependent Life selection should become effective (because Dependent Life coverage is added or there is an increase in the level of Dependent Life), the effective date will be the date the spouse or child is discharged or no longer confined. To be confined elsewhere means the spouse or child is unable to perform the normal functions of daily living or is unable to leave home without assistance.

If MetLife denies coverage, refer to the Optional Life Insurance denial information on Page 50.

Supplemental Long Term Disability

Changes allowed throughout the year:

- Cancel coverage — effective the first of the month following the request.
- Increase the waiting period from 90 to 180 days — effective the first of the month following the request.
- Decrease the waiting period from 180 to 90 days, which requires medical evidence – effective the first of the month following approval.
- Add coverage if late entrant, which requires medical evidence – effective the first of the month following approval.

For late entrants, a *Medical History Statement* must also be completed and sent to Standard Insurance Company for review. If approved, a copy of the approval will be mailed to the employee and the benefits administrator. The approval letter from The Standard must be attached to the NOE and submitted to PEBA.

MoneyPlus

Flexible spending accounts

Medical Spending and Dependent Care Spending accounts can be changed during the year only if an approved change in status event occurs and the election change is consistent with the event.

Health Savings Accounts (HSAs)

Contributions can be started at any time and stopped or changed on a monthly basis. Changes become effective the first of the month following the change.

Pretax contribution changes to HSAs must be made on a prospective basis. **Employees cannot make retroactive changes.**

To change an HSA, active employees should complete a paper *Notice of Election* form. Mark *Contribution Amount Change* and the new plan year

total amount in Box 27C. To stop HSA contributions, enter $0.

- As the benefits administrator, when you sign and date the form, you are also certifying the employee's eligibility to continue contributing to an HSA.
- Each employer's payroll center may specify when the enrollment form must be received to allow enough time to change the payroll withholding.

Employees may also contribute directly to their HSAs, through Central Bank, on an after-tax basis, according to IRS guidelines.

To close an HSA account with Central Bank:
Step 1. The employee must stop contributing to his account. He must complete and submit a *Notice of Election* form, entering $0 in Box 27C of the form to stop the payroll deductions. Both the employee and benefits administrator must sign this form. Completing the NOE does not close the HSA at Central Bank.

Step 2. To close the HSA with Central Bank, the employee must contact Central Bank.

Do not advise employees to leave their HSAs open with a $0 balance. If the employee does not close his account with Central Bank, the monthly $1.25 maintenance fee will continue, resulting in an overdraft, compounded by additional charges. If there is money remaining in the HSA, the employee may continue to use the money for qualified medical expenses. When the account balance drops below $25, he should use the rest and contact Central Bank to close the account.

Beneficiary changes

Basic Life/Optional Life

Encourage subscribers to initiate a beneficiary designee change for Basic Life and/or Optional Life in MyBenefits.

Or use EBS when an employee wants to change a beneficiary. Select Beneficiary as the Reason for Change. Complete the change and apply to MyBenefits or Current EBS.

If using a paper *Notice of Election*, an attachment is acceptable when the number of designated beneficiaries exceeds the spaces on the NOE. Indicate on the NOE that beneficiaries are continued, or may be listed entirely, on an attachment.

- On the attachment, indicate the employee's name, SSN and the life insurance benefit with the same beneficiary information that is requested on the NOE. The attachment must be signed and dated by the subscriber and stapled to the NOE.

When multiple beneficiaries are listed, indicate percentages; otherwise, the money will be divided equally among beneficiaries. The percentages must total 100 percent and must be whole numbers — no decimals.

The effective date will be the subscriber's signature date on the requested change.

Open enrollment for active subscribers

During the October open enrollment period, eligible employees may change their coverage without having to have a special eligibility situation. Changes become effective the following January 1.

- Employees may enroll themselves, enroll or add their eligible spouse and/or their eligible children in health and/or dental insurance.
- Employees may cancel health coverage or drop their spouse and/or children from health coverage.
- Employees may change from one health plan to another.
- Employees may enroll in or drop State Vision Plan coverage for themselves, their eligible spouse and/or their eligible children.

- Employees may enroll or re-enroll in MoneyPlus features as follows:
- Employees remain on the MoneyPlus Pretax Group Insurance Premium feature and do not need to re-enroll.
- Permanent full-time employees must re-enroll in the MoneyPlus Medical Spending Account and/or Dependent Care Spending Account each year.
- Medical Spending Account participants receive the debit card at no charge. Note that a new card is not sent to the participant each year; *the card is valid for five years.*
- Employees do not need to re-enroll in the Health Savings Account each year, if they wish to continue contributing the same amount. If they wish to change the amount they contribute, they can indicate a new amount in MyBenefits. If they wish to stop contributions or are no longer eligible to contribute, enter $0.
- Employees enrolling in an HSA and who currently have a full (not a limited-use) Medical Spending Account can begin contributing to their HSA on January 1, if the MSA has a zero balance as of the last day of the previous plan year (December 31). MSAs are considered *other health insurance*. They will still be able to contribute the full annual amount to their HSA, as long as they remain eligible through the end of the plan year and continue to be eligible for a full 12 months after that.
- Employees participating in the MoneyPlus Pretax Premium feature may elect, make changes or cancel Optional Life. Medical evidence may be required. This does not affect the employee's eligibility to participate in an MSA or a DCSA.
- Changes to other benefits may be made as announced.

Dental coverage

- Employees may enroll in, cancel or add or drop spouse and/or children from Dental Plus or Basic Dental only during open enrollment of **odd-numbered years**.

Open enrollment procedures and helpful hints

You do not have to wait until October 1 to begin enrollment. You may begin early, if you wish.

- PEBA will make enrollment materials available as early as possible and will notify you through *PEBA Update* as they are printed and/or posted on the PEBA website. Be sure that NOEs and MyBenefits are ready before you tell your employees to start making their enrollment changes.
- Distribute *Insurance Summary* and federally mandated notices to insurance-eligible employees prior to open enrollment.

Encourage employees to use MyBenefits to initiate any open enrollment changes and upload supporting documentation.

After October 31, the employee's open enrollment decision is final; he does not have 31 days to change his mind.

When making coverage changes on dependents, any spouse or children to be added or deleted must be listed. Social Security numbers and dates of birth are required.

If using a paper *Notice of Election*, **only** the requested changes need to be marked. If anything else is marked, be sure it is marked correctly to avoid unnecessary rejections or unintended changes. Check the box Enrollment under TYPE OF CHANGE in the Administrative Information section.

- If more than one NOE is submitted, PEBA will process the NOE with the latest signature date as the final, enrollment NOE.
- NOEs must be signed by October 31.

- NOEs must be signed by the benefits administrator and by the employee.
- Upload any required documentation to EBS or staple it to the NOE.
- Do not hold enrollment NOEs. Send them to PEBA as they are completed.

All open enrollment transactions must be received by PEBA by November 15; no exceptions.

If there is also a change of address, complete a universal *Name/Address Change Form* and submit it to PEBA immediately.

New employees or transfers hired October 2-December 31

Transfers

Employees who transfer from one participating employer to another with no break in coverage must make their open enrollment elections with the previous employer in October.

- The subscriber must advise the new employer of his open enrollment elections at the time of the transfer.
- The employee will need to complete a new hire NOE, change reason: Transfer, showing the current coverages with the new employer. The employee will also need to complete an NOE showing the open enrollment changes with the new employer. The employee and benefits administrator must sign, and the NOEs must be sent to PEBA.

Unpaid leave or reduction in hours

General leave policies

PEBA does not dictate the employment status of an employee, only the coverage that is available to the employee through PEBA's programs. **While on paid leave, an employee's eligibility for benefits continues, and the employer should pay the employer's share of any premiums during the paid leave.**

This section describes how eligibility for insurance benefits is affected when an employee goes on an employer-approved leave of absence that is not associated with military leave or FMLA. See the Quick reference for unpaid leave or reduction in hours on Page 179 for more information.

Employees with unpaid leave or reduction of hours

Ongoing employees

Any employee employed during the Standard Measurement Period (October 4-October 3) is an ongoing employee. Eligibility for benefits is based on the number of hours the employee worked during the Standard Measurement Period.

If the employee averaged 30 hours per week during the Standard Measurement Period, he is in a Stability Period and a reduction in hours (even to zero) does not make the employee ineligible for benefits. As long as the employee remains employed with the employer, his eligibility for benefits continues for the remainder of the stability period.

Provide the employee with the *Your Insurance Benefits When Your Hours are Reduced* form, which is under Insurance Benefits/Forms/Affordable Care Act (ACA). The employee's benefits will continue and the employee cannot cancel coverage unless one of the following occurs:

- The employee experiences a special eligibility situation such as a gain of other coverage. In this case, the benefits administrator should submit an NOE or SOC with the supporting documentation.
- The employee intends to enroll in coverage through the Health Insurance Marketplace. In this case, the benefits administrator should submit the *Active Termination Form* to PEBA using EBS. All active termination forms should be submitted using EBS except for those who are on military leave. Check

the box in the Reduction of hours section and sign. Because the employee is voluntarily terminating coverage, neither the employee nor his covered dependents is eligible for COBRA. The employee is also not eligible to be covered as a dependent spouse since he is eligible for benefits as an active employee. Once the employee cancels his active coverage, the employee may not re-enroll in benefits until the next open enrollment period, if eligible, or within 31 days of a special eligibility situation.

If the employee did not average 30 hours per week during the Standard Measurement Period, he is not in a Stability Period and a reduction in hours of less than 30 per week makes the employee ineligible for benefits.

Provide the employee with the *Your Insurance Benefits When Your Hours are Reduced* form. Because the employee's hours have been reduced, the employee is no longer employed in a benefits-eligible position. Eligibility for benefits ends the first of the month following the reduction in hours. Provide the employee with the 18-month COBRA Notice and, if enrolled in life insurance, the PEBA Coverage Verification Notice of Group Life Insurance. Submit the *Active Termination form* to PEBA in EBS. All active termination forms should be submitted using EBS except for those who are on military leave. Check the T5 box, Not Eligible (Not in a Stability Period.) In EBS, choose Left Employment.

New full-time Employees (Not Employed for the Standard Measurement Period)

These employees are not in a Stability Period. A reduction in hours of less than 30 per week makes the employee ineligible for benefits.

Provide the employee with the *Your Insurance Benefits When Your Hours are Reduced* form. Because the employee's hours have been reduced, the employee is no longer employed in a benefits-eligible position. Eligibility for benefits ends the first of the month following the reduction in hours. Provide the employee with the 18-month COBRA Notice and, if enrolled in life insurance, he will receive a conversion packet from MetLife. Submit the *Active Termination Form* to PEBA in EBS. All active termination forms should be submitted using EBS except for those who are on military leave. Check the T5 box, Not Eligible (Not in a Stability Period.) In EBS, choose Left Employment.

Variable-Hour, Part-time, or Seasonal Employees (Within an Initial Stability Period)

If the employee averaged 30 hours per week during his Initial Measurement Period, he is in his Initial Stability Period and a reduction in hours (even to zero) does not make the employee ineligible for benefits. As long as the employee remains employed with his employer, the employee remains eligible for benefits through the end of his Initial Stability Period.

Provide the employee with the *Your Insurance Benefits When Your Hours are Reduced* form. The employee's benefits will continue, and the employee cannot cancel coverage unless one of the following occurs:

- The employee experiences a special eligibility situation, such as a gain of other coverage. In this case, the benefits administrator should submit an NOE or SOC with the supporting documentation.
- The employee intends to enroll in coverage through the Health Insurance Marketplace. In this case, the benefits administrator should complete the *Active Termination Form* to PEBA using EBS. All active termination forms should be submitted using EBS except for those who are on military leave. Check the box in the Reduction of hours section and sign. Because the employee is voluntarily terminating coverage, neither the employee nor his covered dependents is eligible for COBRA. The employee is also not eligible to be covered as a dependent spouse since he is eligible for benefits as an active

employee. Once the employee cancels his active coverage, the employee may not re-enroll in benefits until the next open enrollment period, if eligible, or within 31 days of a special eligibility situation.

Once the employee's Initial Stability Period ends, he becomes an ongoing employee and continued eligibility should be based on his hours worked during the Standard Measurement Period (October 4-October 3). Refer to Ongoing Employees section on Page 56.

Premiums while on unpaid leave

Only employees who are within a stability period or employees who are absent from work due to FMLA or military leave may continue their coverage with their employer when their hours are reduced below 30 per week. All other employees lose eligibility for benefits when their hours are reduced below 30 hours per week, and these employees should be offered COBRA continuation coverage. The benefits administrator should submit the *Active Termination Form* to PEBA in EBS. All active termination forms should be submitted using EBS except for those who are on military leave. Check the T5 box, Not Eligible (Not in a Stability Period.) In EBS, choose Left Employment.

Eligible employees are responsible for paying only the employee's share of the premium while on unpaid leave. All premiums should be paid to the employer by the first of the month. If an employee fails to pay his employer by the first of the month, the employer can cancel his coverage due to nonpayment by submitting an Active Termination form to PEBA.

If an employer fails to submit an *Active Termination Form* to terminate coverage due to nonpayment within the month payment is due, coverage will be terminated the first of the month after request.

There is a 31-day grace period for employees to make payment and have coverage reinstated. If the employee makes payment before the end of the grace period, the benefits administrator can submit a Request for Review form to PEBA requesting the employee's coverage be reactivated, because the employee submitted payment within the payment grace period. Coverage will be reinstated retroactively to the termination date.

Cancellation due to non-payment is not a COBRA qualifying event. No COBRA notice should be sent to the employee or his covered dependents. The employee may not re-enroll in benefits until the next open enrollment period, if eligible, or within 31 days of a special eligibility situation. **Please note: Returning to work is not a special eligibility situation that allows an employee to re-enroll in benefits.**

SLTD and life insurance benefits while on unpaid leave

- SLTD benefits will end 31 days after the last day worked. Complete an *Active Termination Form* to terminate employee's SLTD coverage. Under Section C, Plan and Dates, mark SLTD only and list the effective date.
- Life Insurance benefits end 12 months after the last day worked. Complete an Active Termination Form to terminate employee's life coverage. Under Section C, Plan and Dates, mark, as appropriate, Dependent Life/Child, Dependent Life/Spouse and/or Optional Life. List the effective date.

Continuing MoneyPlus while on unpaid leave

If the employee remains eligible for benefits, and he decides to continue his MoneyPlus contributions to his spending accounts, he can continue only until the end of the calendar year in which he begins unpaid leave. There are three ways to manage an employee's spending account elections during unpaid leave:

1. **Prepay**. The employee is given the opportunity to prepay his contributions on a pretax basis.

- **Health Savings Account** — the same rules apply to contributions to the employee's HSA.

2. **Pay-as-you-go**. The employee is given the opportunity to pay with after-tax and/or pretax dollars (to the extent the employee receives compensation during leave).

    - Collect the contributions from the employee and include the money with the deposit covering the active employee contributions for any given payroll period.
    - The employer must send payroll funding and participant remittances to ASIFlex via ACH or mail to P.O. Box 6044, Columbia, MO 65205-6044.
    - **Health Savings Account** — Employees may also contribute directly to their HSAs through Central Bank on an after-tax basis. If they choose to do this, there is nothing for the employer to report.

3. **Catch-up**. The employee and the employer agree that the employer pays the contribution on the employee's behalf during leave, and the employee repays the employer upon return. Provisions for catch-up are between the employer and the employee. This must be decided prior to leave. PEBA assumes no liability for this option.

    - **Health Savings Account** — This option does not apply.

If the employee remains eligible for benefits, and he decides not to continue his MoneyPlus contributions:

- Notify ASIFlex via the employer portal that the person is on unpaid leave and will not be continuing his contributions.
- Notify ASIFlex via the employer portal when the person returns from leave if his contributions will resume.

If the employee's unpaid leave makes him ineligible for benefits, refer to Page 83 regarding the procedures for terminating participation in MoneyPlus accounts.

Military leave

The Uniformed Services Employment and Reemployment Rights Act (USERRA) requires employers to provide certain reemployment and benefits rights to employees who serve or have served in the uniformed services. The administration of military leave is based on the employer's policy and applicable laws. The general COBRA rules are modified to allow an employer to fulfill the requirements of USERRA when an employee takes military leave. Except as noted below, military leave should be administered as regular unpaid leave.

- At the beginning of military leave (regardless of whether leave is paid or unpaid), an employee may continue or drop all of his coverage.
- If the employee chooses to continue coverage, the employer must continue to pay the employer share of the premiums for any period of paid military leave and then continue to pay the employer portion as long as the employee is in a stability period.
- If the employee chooses to terminate coverage, submit the *Active Termination Form* and a copy of the military orders to PEBA when the employee begins military leave. An employee on military leave is eligible for a total of 36 months of COBRA continuation coverage. Provide the employee with the 36-month COBRA Notice and, if he is enrolled in life insurance, he will receive a conversion packet from MetLife.
- When the employee returns from military leave, the employee may re-enroll in coverage within 31 days of returning to work.
- If the employee terminated coverage and he returns to work within 15 calendar days or does not experience a break in coverage,

the employee may reenroll in the same benefits he was enrolled in prior to military leave.
- If the employee terminated coverage and he returns to work more than 15 calendar days later or he experiences a break in coverage, the employee may make elections as a new employee.
- An employee returning from military leave may reinstate his life insurance at the same level he had prior to going on military leave without evidence of insurability, regardless of when he returns to employment, as long as he is honorably discharged.
- SLTD coverage may also be reinstated without medical evidence.

If a special eligibility situation occurred while the employee was on military leave, and he did not continue his coverage through PEBA, he may add the newly eligible spouse and/or children when he returns to work by providing documentation of the special eligibility situation.

Family and Medical Leave Act (FMLA)

The Family and Medical Leave Act of 1993 (FMLA) requires qualifying employers to provide job-protected leave, continuation of certain benefits and restoration of certain benefits upon return from leave for specific family and medical reasons. The administration of FMLA leave is based on the employer's policy and applicable laws. In most cases, the employee will not make changes to benefits and will return from FMLA leave, and no action will be required. However, if he does wish to make changes during FMLA, the following rules allow an employer to fulfill the requirements of FMLA when an employee takes FMLA leave.

Under FMLA, eligible employees of qualifying employers are entitled to 12 work weeks of leave in a 12-month period for:

- Birth of a child and to care for the newborn child;
- Placement of a child with the employee for adoption or foster care;
- Care for a family member (child, spouse or parent) with a serious health condition;
- Their own serious health condition; and
- Any qualifying exigency arising if the employee's spouse, son, daughter, or parent is a covered military member on covered active duty.

Under FMLA, eligible employees of qualifying employers are entitled to 26 work weeks of leave in a 12-month period for:

- An employee who is a spouse, son, daughter, parent, or next of kin of a covered service member with a serious injury or illness to provide care for that service member.

The FMLA regulation 29 CFR section 825.209 Maintenance of Employee Benefits states: An employee may choose not to retain group health plan coverage during FMLA leave. However, when an employee returns from leave, the employee is entitled to be reinstated on the same terms as prior to taking the leave, including family or dependent coverages, without any qualifying period, physical examination, exclusion of pre-existing conditions, etc. See §825.212(c).

During FMLA leave, an employee remains eligible for benefits even if his hours reduce below 30 hours per week and even if the employee is not in a stability period. No action is required by the employer when an employee goes on FMLA leave unless the employee chooses to cancel his coverage.

If the employee chooses to keep coverage during FMLA leave, the employer must pay the employer share of the premiums for any period of FMLA leave, regardless of whether the leave is paid or unpaid.

- The employer must provide the employee advance, written notice of the terms and conditions under which the employee premium payment must be made if the premiums are not being payroll deducted.
- **There is a 31-day grace period on premium payments**. If the employee fails to make a timely payment within 31 days, the employer may:
- Pay the employee's share of premium payments for the remainder of the leave period and recover the amount from the employee when the employee returns to work. PEBA assumes no liability for this option.
- Cancel the employee's coverage. *The employer must give the employee written notice at least 15 days before coverage would end.* PEBA will refund a maximum of 31 days retroactive of premiums.
- Send an Active Termination Form marked non-payment. If the employee returns to work before FMLA leave is exhausted, the employee may reinstate coverage the first of the month following his return to work. Write on the top of the NOE, Employee returning from FMLA.

If the employee fails to return to work after exhausting FMLA leave, the employer may make the following benefits decisions.

- The employer may allow the employee to continue employment.
- If the employee is on paid leave, benefits continue and no action is required.
- If the employee is on unpaid leave, refer to the Unpaid Leave section beginning on Page 56 to determine if the employee is eligible to continue benefits based on his status (ongoing employee, new full-time, new variable-hour, etc.).
- The employer may terminate employment.
- The employer offers the employee and his covered dependents 18 months of COBRA continuation coverage due to a reduction in hours. The date of the COBRA qualifying event should be listed as the last day of FMLA leave. Even if the employee canceled coverage during FMLA leave, COBRA continuation coverage should be offered at the end of FMLA leave if the employee does not return to work after exhausting FMLA leave.
- See Transfers and terminations (Page 63) and COBRA Subscribers (Page 74) for additional procedures.

If the employee chooses to terminate coverage during FMLA leave:

- Submit an NOE to PEBA refusing all coverage. List change reason as Employee on FMLA.
- Upon return from FMLA leave, most employees are restored to their original or equivalent positions with equivalent pay, benefits and other employment terms.
- If the employee returns before FMLA leave is exhausted, the employee's coverage should be reinstated on the same terms and conditions without any qualifying period or evidence of insurability.
- The request to reinstate coverage must be made within 31 days of returning to work.
- Write on top of the NOE, Employee returning from FMLA.
- If the employee does not return to work at the end of FMLA leave, the employer should send the employee and his covered dependents the 18-month COBRA Notice. The date of the COBRA qualifying event should be listed as the last day of FMLA leave.

Workers' compensation

Workers' compensation is not administered as unpaid leave. An employee, on approved leave because of disability approved by the Office of Workers' Compensation Programs, **is considered to be drawing a salary from the state**.

- All coverage must continue as before during the benefit period, unless a change in status/special eligibility situation occurs. Documentation may be required.
- The employee pays the employee's share of premiums to the employer's payroll office.
- The employer pays the employer portion of premiums.
- If the employee has stopped making payments for his share of the premiums, the employer may continue the coverage and request repayment of the employee's share once he returns to work.
- If the employer does not wish to continue the employee's coverage because he has stopped paying his share of the premiums, the employer should consult with its legal counsel before terminating the employee's coverage.
- To terminate the coverage, the employer should send an Active Termination Form marked nonpayment. The employee may reinstate coverage within 31 days of his return to work. Otherwise, he may enroll within 31 days of a special eligibility situation or during open enrollment.

Affordable Care Act reporting requirements

Employers who participate in the State Health Plan have certain requirements under the Affordable Care Act. Employers must provide subscribers with proof of health coverage by issuing forms to subscribers. Each year, the IRS determines the date by which employers must send the forms to subscribers.

Employers with less than 50 employees

- Issue IRS Form 1095-B to any active employees enrolled in health coverage at any time during the previous calendar year.

Employers with 50 or more employees

- Issue IRS Form 1095-C to any employees who were eligible for health coverage at any time during the previous calendar year.

All employers except members of the State Applicable Large Employer (ALE) group

- Issue IRS Form 1095-B to any non-Medicare retirees or COBRA subscribers enrolled in health coverage at any time during the previous calendar year.

PEBA issues Form 1095-B to any non-Medicare retirees or COBRA subscribers for members of the State ALE group. PEBA also issues Form 1095-B for employers who are able to designate PEBA as its Designated Governmental Entity (DGE).

Only an employer required by statute to participate in the State Health Plan (Governmental Employer) may elect to designate the South Carolina Public Employee Benefit Authority (PEBA) as its designated governmental unit. To do so, the employer must complete and submit the Designated Governmental Entity form. Optional employers are unable to designate PEBA as their Designated Governmental Entity (DGE).

Employers must also submit Forms 1094-B or 1094-C to the IRS. Each year, the IRS determines the date by which to submit these forms.

To assist employers with their reporting requirements, PEBA will post a file on EBS each year that contains information about their employees and dependents who were enrolled in health coverage at any time during the previous calendar year. For additional information, call PEBA's BA Contact Center or email Denise Hunter at dhunter@peba.sc.gov.

Transfers and terminations

Transfers and terminations

Assisting a transferring employee

For PEBA's insurance purposes, a **transfer** is defined as an active employee who moves from one participating employer (losing employer) to another participating employer (gaining employer) with no break in benefits or with no more than a 15-calendar-day break in employment.

An **academic employee**, who completes a school term and moves to another academic setting at the beginning of the next school term, is also considered a transfer, not a new hire. Coverage remains in effect through the summer.

Generally, when he transfers, an employee will remain enrolled in the same insurance benefits. Contact PEBA for coverage information.

Transferring out (losing employer)

Once the employee notifies you of his intention to transfer to another participating employer without a 15-day break in employment or with no break in insurance coverage, submit the transfer to PEBA.

Enter the transfer as a termination in EBS. Select *Transfer* from the *Reason for Termination* drop-down list. Enter the Transfer Group ID and effective date. EBS provides an *Employer Group ID Help* feature.

If the employee is on the payroll on the first day of the month, then the employee is covered by the transferring agency until the last day of the month. *Example:* Employee's termination date is May 1; employee's insurance will transfer effective June 1.

Once the transfer is applied, a *Summary of Termination* (SOT) can be saved or printed for your records. Do not mail the document to PEBA.

If the transfer cannot be completed in EBS or a correction needs to be made after the transaction in EBS, complete a paper *Active Termination Form* and return to PEBA. Mark the reason for termination as Transfer (TT) and include the gaining employer name and ID number. Please allow additional time for processing of paper forms.

PEBA will produce an active benefits transfer form for the benefits administrator at the new employer. The form lists an employee's benefits and his covered spouse and/or children. The employee may change his address, telephone number, Basic Life and Optional Life beneficiaries on the form, if necessary.

The gaining employer does not have to wait until receipt of the transfer form to complete the enrollment in EBS.

COBRA applies to transfers

COBRA notification for continuation of health, dental and vision coverage must be sent to transferring employees, their covered spouses and covered dependent children.

When an employee transfers, COBRA notification is not required for MoneyPlus accounts. PEBA will notify the MoneyPlus administrator of any transferring employee who has a MoneyPlus account.

Academic transfers

Employees of public school districts, universities, colleges and technical colleges are considered academic employees and are subject to the termination and transfer rules below.

These rules apply, regardless of when the benefits administrator receives the resignation.

- Academic employees, who complete a school term and move to another participating academic employer, are considered academic transfers, even though they may not work during the summer.
- The losing academic employer must continue to cover academic transfer employees during the summer, pay the employer share of premiums, collect premiums from the employee and terminate coverage at the beginning of the

fall term (September 1) to avoid a break in coverage.

- Exceptions may be made for academic positions that begin employment during the summer, such as, but not limited to, coaches, principals and superintendents. If you use an NOE, be sure to write the employee's position at the top of the NOE so that the PEBA staff will know this is an exception.
- If *not* transferring or if working for the summer:
    - Academic employees, who are leaving employment and do not plan to transfer to another academic setting, should be terminated effective the first of the month following the last day worked. If an academic employee terminated employment at the start of summer, but returns to an academic setting in the fall, he is still considered a transfer. The employee must pay the back premiums for the summer months to his losing employer to avoid a break in coverage.
- If the academic employee was planning to return to an academic setting in the fall, **but decided to retire retroactively**, he should be terminated effective the first of the month following the last day worked. If the employee is eligible for retiree coverage but has missed the 31-day window to enroll, he should contact PEBA.
- Academic employees who work during the summer session, **but who are not transferring to another academic setting in the fall**, should be terminated from coverage effective the first of the month following the last day worked.
- The academic employer determines the eligibility status by contract with each employee and position. The summer session may or may not be considered permanent, full-time employment.
- The termination effective date from the losing academic employer should coincide with the effective date of the gaining academic employer, **reflecting no break in coverage.**
- Academic employees who are retiring effective July 1 should be terminated from active coverage July 1.

Permanent, part-time teacher transfers

A permanent, part-time teacher, who transfers from one academic employer to another with no more than a 15-calendar-day break in employment or with no break in coverage, should be considered a transfer and must keep the same coverage. The health and/or dental premium may change if the number of contract hours places the teacher in a different category. He may make changes based on the increase or decrease in hours as explained in the Active Subscribers section of this manual.

Change in status during the transfer

If a change in status or special eligibility situation occurs, and:

- The effective date of the change in status event falls before the effective date of the employee's transfer, the employee must contact the losing employer to complete an NOE for the change. Forward the completed NOE, along with any required documentation, to PEBA. PEBA will send a new transfer form to the gaining employer.
- If the effective date of the change in status falls on or after the effective date of the employee's transfer, the employee must contact his new employer to complete an NOE for the change. Coverage changes or add/drop a spouse and/or children cannot be completed as part of the transfer.

Transferring in (gaining employer)

Confirm that the employee is a transfer from another participating employer:

- You may have received a transfer form from PEBA if the losing employer completed the termination in a timely manner; or
- The employee may give you a copy of his termination and/or creditable coverage letter.

You do not have to wait until the transfer form is received to enter transferring employee into EBS.

Contact PEBA if you have any questions about the status and eligibility of the transferring employee.

If you have questions about the transferring employee's MoneyPlus status, verification of contribution amounts can be found on the HIS763NP report in EBS. You can also contact ASIFlex.

Be sure that the transferring employee is offered the same orientation given to new employees with your group and review the COBRA regulations.

Documentation, such as proof of dependent eligibility, court orders and incapacitated child certification, is **not** needed if previously established.

The effective date of the gaining employer should coincide with the termination effective date from the losing employer, reflecting no break in coverage. If the employee is on the payroll on the first day of the month, then the employee is covered by the losing employer until the last day of the month

If the effective date of loss under the losing employer is before the hire date for the gaining employer, but within 15 days, the employee's date of hire should be entered in EBS as the effective date of loss under the losing employer.

Academic transfers

The termination effective date from the losing academic employer should coincide with the effective date of the gaining academic employer, **reflecting no break in coverage.**

He must be enrolled in the same coverage he had previously. Contact PEBA for coverage information.

His previous employer must:

- Pay the employer share for his coverage, retroactively, for the summer to avoid a break in service, unless the employee works in a position that is an exception as explained on Page 65.
- Collect the employee share of coverage, retroactively, from the employee and include it with the employer payment.

Enrolling the transferring employee through EBS

When you receive an active benefits transfer form from PEBA, complete the transfer in EBS by initiating an enrollment. You do not have to wait until the transfer form is received to enter the transferring employee into EBS.

Have the employee review the transfer form and make any necessary and/or allowed changes. The employee's information and coverage levels will be prepopulated in EBS. A spouse and/or child(ren) may not be added to, or deleted from, any benefit, unless a qualifying change in status has occurred.

Apply the transaction to MyBenefits for the employee to electronically approve and sign or Current EBS for a signature page to be signed by the employee. The transfer form can also be uploaded and submitted with the signed signature page. Refer to Page 16 for more information.

Active benefits transfer form

The active benefits transfer form lists the employee's benefits and his covered spouse and/or child(ren). The employee may change his address, telephone number, Basic Life and Optional Life beneficiaries on the form, if necessary. Coverage and dependent changes are not allowed.

If the transfer is not completed in EBS with an enrollment transaction, complete the transfer form and return it to PEBA. Please allow additional time for processing of paper forms.

Please note the following about section A:

- **Effective Date:** Should reflect no break in coverage between employers. Verify there was no more than a 15-calendar-day break in employment or no break in insurance coverage to confirm the transfer status.
- **Annual Salary:** List the annual contract salary. Do not include any additional pay other than the contract salary. Groups affected by furloughs should use the non-furlough salary. This salary will be used to calculate the SLTD premium if the transfer has SLTD coverage.
- **Employment Date:** First day physically at work.
- **Pay Periods:** Number of annual pay periods.
- **Pretax (MoneyPlus):** Y, N or Blank. You may need to confirm this with PEBA or the previous employer.

Mailing address, email address or telephone number changes are allowed. The employee should mark a single line through any information that needs to be updated and legibly print the new information.

Coverage through Medicare or another policy for a subscriber, spouse or child is included, if applicable.

Coverage and levels are included in the Coverage section. The employee may make limited changes to his life and SLTD coverage by completing an NOE. See Using an NOE Instead of EBS on Page 69.

The spouse and/or child(ren) on file at the time of the transfer from the previous employer is included. The benefits under which each spouse or child is covered is indicated with an X beside the spouse or child's name.

The employee may correct any spelling of names, dates of birth, SSNs (copy of card required if not a keying error by PEBA), or add any missing information by submitting an NOE.

A spouse and/or child(ren) may not be added to, or deleted from, any benefit, unless a qualifying change in status has occurred. *Exception*:

Dependent Life coverage may be added or dropped throughout the year.

The beneficiaries are listed as reflected in PEBA's records. **Changes are allowed in this section.** If the employee wishes to make a beneficiary change:

- He should mark through the beneficiary including the asterisk (*), initial the mark-through and write or type in the new beneficiary, including all necessary information, on the first available line.
- He must indicate the benefit (Basic Life, Optional Life) with an asterisk (*) in the space under the benefit.
- If enough space is not available to list the new beneficiaries, he should write SEE ATTACHMENT and staple the attachment to the transfer form.
- If more than one beneficiary is designated, he must indicate the appropriate percentages and whether each beneficiary is primary or contingent.

If the employee has health coverage, a beneficiary for Basic Life must be indicated. If this field is blank, the employee must add a BL beneficiary.

The employee and benefits administrator must sign and date the form. Make a copy for your files and the subscriber. Return the original to PEBA for processing.

Change in status during transfer

If a change in status or special eligibility situation occurs, and:

- The effective date of the change in status event falls before the effective date of the employee's transfer, the employee must contact the losing employer to complete an NOE for the change. That employer must send the completed NOE, along with any required documentation, to PEBA. PEBA will send a new transfer form to the gaining employer.
- If the effective date of the change in status event falls on or after the effective date of

the employee's transfer, the employee must contact his new employer to complete an NOE for the change. Coverage changes or add/drop a spouse and/or children cannot be completed as part of the transfer.

Using an NOE instead of EBS

Use a Notice of Election (NOE) only when:

- The losing employer has not terminated the transferring employee. If NOE is received before the employee is transferred, it will be rejected.
- The employee wants to make the following changes to his coverage:
    - **Dependent Life**: Add, increase or drop coverage on a spouse and/or child(ren). Evidence of insurability is required to add or increase coverage on a spouse.
    - **Optional Life**: Increase, decrease or drop coverage allowed only if NOT participating in the MoneyPlus Pretax Group Insurance Premium feature. Evidence of insurability is required to increase coverage. Employees participating in the MoneyPlus Pretax Group Insurance Premium feature can increase, decrease or drop coverage only during annual enrollment or within 31 days of a change in status.
    - **SLTD**: Enroll or decrease to a 90-day waiting period with evidence of insurability. May also drop SLTD coverage.
- A change in status or special eligibility situation has occurred. If you have an active benefits transfer form, attach the NOE and any required documentation and send to PEBA for processing. See Change in status during transfer on Page 68.

If using an NOE, it must be completed in its entirety.

- Check **Transfer** at the top of the NOE.
- Contact PEBA to obtain levels of coverage.
- Remember to attach any required documentation listed beginning on Page 69.

Transfers — new employer created or lateral transfer

New employer created by interdepartmental transfers or lateral transfers from one employer to another (restructuring).

Employer ID numbers will change on all files (PEBA insurance benefits, PEBA retirement benefits and all plan administrators) for employees of new employer groups created by interdepartmental or agency reorganizations.

The same policies and procedures govern employees who are laterally transferred from one employer to another.

Each employee will be terminated from the old employer and added to the new employer, with no break in coverage and with the same coverage.

Other coverage changes are permitted only if a special eligibility situation occurs. Documentation may be required.

Old employer procedures (losing employer)

Before the effective date of the transfer:

- Resolve all rejections for any employees being transferred.
- Process and send to PEBA any eligible changes in status for applicable benefits and coverage or Optional Life changes that occur before the effective date of transfer.
- The employees' names, SSNs, old employer ID number and new employer ID number with effective date of transfer must be sent to PEBA.
- Give all benefits documentation, including COBRA notification letters, to the new employer at the time of transfer.

New employer procedures (gaining employer)

Before the effective date of the transfer:

- Send letter of notification to PEBA with the following information:
  - Departing employer and ID number;
  - New employer and ID number;
  - Effective date of change; and
  - SSN and name of each employee being transferred.
- Send a copy of the notification letter to the losing employer.
- Place a copy of the notification letter in each employee's file.

The new employer must process any eligible family status changes that occur after the effective date of transfer.

Transfers — dual employment

Employee working for two participating employers

If an employee is working for two participating employers, he is considered working for one employer or the other for insurance purposes. He cannot be considered working for both employers.

The employee **cannot** have his insurance coverage and premiums split between the two employers, nor may he combine his two salaries for Optional Life/Dependent Life insurance purposes**.**

If an employee starts working for a second participating employer and wants his insurance coverage to be with the new employer, he is considered a transfer. He has 31 days to have his transfer processed. If the 31-day window is missed, his coverage remains with the first employer.

The standard procedures for transferring the employee apply, including the procedures for transferring out, transferring in and COBRA notification as explained earlier in this section.

Terminations

General rules for terminating active employees

Submit terminations in EBS immediately.

All changes in employment or special eligibility situations resulting in a termination of coverage must be processed within 31 days.

If submitting a termination outside of the 31 days, complete and send an *Active Termination Form*. Mark only one reason for termination.

Retroactive terminations

Maximum 31 days retroactive (to be calculated from the date received by PEBA)

Terminations may be no more than 31 days retroactive. *Exception*: If PEBA receives an *Active Termination Form* that is more than 31 days retroactive, it will be accepted and processed only if it is accompanied by an NOE (such as a COBRA NOE or Retiree NOE) that shows the subscriber is continuing coverage, and with no break in his coverage.

If a termination is received **more than 31 days** from the date of loss of eligibility, PEBA will cancel coverage the first of the month after the date of receipt.

During December, retroactive terminations should be submitted on an *Active Termination Form*, rather than through EBS, if the subscriber makes a change with an effective date of January 1.

Academic employees

If not transferring or if working during the summer:

- Academic employees, who are leaving employment and do not plan to transfer to another academic setting, should be terminated the first of the month following the last day worked.
- If an academic employee terminated employment at the start of summer, but returns to an academic setting in the fall, he is still considered a transfer. The employee

must pay the back premiums for the summer months to his losing employer to avoid a break in coverage.

- Academic employees who work during the summer session, **but who are not transferring to another academic setting in the fall**, should be terminated from coverage the first of the month following the last day worked.
- The academic employer determines the eligibility status by contract with each employee and position. The summer session may or may not be considered permanent, full-time employment.
- Academic employees who are retiring effective July 1 should be terminated from active coverage July 1.
- You must refund overpaid premiums if the premiums are deducted on a prorated scale to cover the summer months. Advance deduction of premiums does not constitute continuous coverage.

COBRA notification required

If an employee's coverage is terminated due to leaving employment, a reduction in hours or service or disability retirement, you should notify the employee and dependents, if applicable, of continuation of coverage as a COBRA participant. Refer to the COBRA section for information on COBRA notification procedures.

Termination due to unpaid leave or a reduction in hours

Refer to the Active Subscribers chapter.

Termination due to non-payment of premiums

Termination is effective the first of the month *following the last month in which premiums were due and paid in full.*

If an employee fails to pay his premiums, submit an *Active Termination Form* to PEBA as soon as possible. Mark the reason for termination as Nonpayment (TN).

If a termination is received more than 31 days from the date of loss of eligibility, PEBA will cancel coverage the first of the month after the date of receipt.

If coverage was terminated due to an administrative error, or because the employee subsequently paid the employer within the 31-day grace period, complete a request for review (RFR) in EBS. Otherwise, the employee and any eligible spouse and/or children must wait until the next open enrollment period or until a special eligibility situation occurs and enroll as late entrants.

Optional employers should complete the appropriate NOE to terminate coverage for retiree, COBRA and survivor subscribers.

If the subscriber is terminated due to non-payment of premiums, do not send COBRA notification letters, since COBRA does not apply.

If the employee returns to work after coverage has been terminated, reinstatement of coverage must be requested within 31 days of returning to work. Otherwise, the employee and any eligible spouse and/or children must wait until the next open enrollment period or until a special eligibility situation occurs and enroll as late entrants.

Other termination information

Life insurance

If terminating employment, the employee may convert his Basic Life, Optional Life, Dependent Life-Spouse and/or Dependent Life-Child coverage to an individual whole life policy. To convert Basic Life, Optional Life, Dependent Life-Spouse and/or Dependent Life-Child coverage to an individual policy at termination of employment, the election must be made within 31 days of the date coverage would otherwise terminate.

MetLife will mail terminated employees a conversion packet via U.S. mail three to five business days after MetLife receives the eligibility

file from PEBA; therefore it is important to submit terminations in EBS in a timely manner. To convert coverage, an employee must follow the instructions in the packet from MetLife. Coverage must be converted within 31 days the date of coverage is lost. It is the employee's responsibility to contact MetLife regarding conversion.

Long term disability

Basic Long Term Disability may not be continued or converted to an individual policy at termination.

Supplemental Long Term Disability (SLTD) may be converted within 31 days of termination if:

- The individual has had SLTD coverage for at least one year;
- The individual is not disabled; and
- The individual is not a retiree.

A *Request for Long Term Disability Conversion Materials* form is available on PEBA's website.

MoneyPlus

Medical Spending Account (MSA) A terminated participant has through the plan year to submit expenses incurred through the date of termination unless he is continuing participation on an after-tax basis through COBRA.

- If continuing an MSA through COBRA, the debit card will be canceled as of the date of termination submitted to PEBA.
- If the termination is due to the death of the employee, his eligible spouse and/or child(ren) may elect to continue the MSA through the end of the plan year. In this case, eligible spouse and/or child(ren) means IRS qualified tax dependents as defined in IRS Publication 502. Otherwise, the spouse and/or child(ren) have through the run-out period to submit any eligible claims incurred through the employee's date of death.

Dependent Care Spending Account A terminated participant has until the end of the year or until the account is exhausted, whichever occurs first, to submit expenses.

Health Savings Account (HSA) A terminated participant may continue to contribute to his HSA, so long as he is covered by a high deductible health plan, whether it is the State Health Plan Savings Plan or another high deductible plan offered by another insurer. He cannot be covered by any other type of health plan. Because he has terminated employment, he would contribute on an after-tax basis directly to Central Bank or other Health Savings Account custodian. He can then include these after-tax contributions on his tax returns according to the IRS guidelines.

- **If he decides to close his HSA bank account with Central Bank**, it is a two-step process. In addition to the termination with PEBA, he must contact the Central Bank HSA Account Holder customer service line at 866.719.2122.
- **Do not advise employees to leave HSA bank accounts open with a $0 balance.** If the bank account with Central Bank remains open, the monthly $1.25 service charge will continue, resulting in an overdraft, compounded by additional charges. When the account balance drops below $25, employees should use the funds and contact Central Bank to close the account.

Reinstating coverage after termination

If an employee has terminated employment, coverage may be reinstated, if done quickly.

If coverage was terminated within the past 15 days:

- Send a letter to PEBA, including reason for reinstatement of coverage. Be sure to include the employee's name, SSN and the effective date for coverage to be reinstated. **Do NOT send an Active NOE or the termination form with Reinstate written on it.**

If coverage was terminated more than 15 days ago:

- The employee is considered a new hire, and coverage cannot be reinstated. Submit an enrollment for the new hire.

Exception: Academic transfers. Send a letter to PEBA, explaining the employee is an academic transfer and include the employee's name, SSN and effective date of transfer. Be sure to follow the academic transfer procedures explained on Page 65.

Affordable Care Act reporting requirements

Employers who participate in the State Health Plan have certain requirements under the Affordable Care Act. Employers must provide subscribers, including terminated employees, with proof of health coverage by issuing forms to subscribers. Each year, the IRS determines the date by which employers must send the forms to subscribers. Learn more on Page 62.

COBRA subscribers

COBRA subscribers

What is COBRA?

Consolidated Omnibus Budget Reconciliation Act

COBRA is a federal law that prevents covered employees and their dependents from losing group health, dental, vision and/or medical spending account coverage as a result of certain qualifying events.

COBRA regulations require that continuation of group insurance coverage be offered to eligible individuals who lose their group medical coverage due to a qualifying event. These qualifying events are listed in the Notices that address 18-, 29-(Extend) and 36-month COBRA continuation.

The following coverage may be continued under COBRA:

- State Health Plan;
- Dental Plus and Basic Dental;
- State Vision Plan; and
- MoneyPlus Medical Spending Account only through the end of the year.

COBRA notification procedures for continuing a Medical Spending Account are different than for health, dental or vision coverage. See Page 83 for information about COBRA procedures for Medical Spending Accounts.

Under COBRA, it is the responsibility of the covered employee, spouse or other family member to notify the benefits office within 60 days of a qualifying event.

View the COBRA employer insurance training materials at peba.sc.gov/insurance-training.

Who is the COBRA administrator?

PEBA coined the term COBRA administrator to identify who collects COBRA premiums and receives notices from COBRA participants.

PEBA serves as the COBRA administrator for former employees of:

- State agencies;
- School districts; and
- Public institutions of higher education.

Benefits administrators of optional employers serve as the COBRA administrator for their former employees.

Assisting a terminating employee

If the employee is not eligible to retire

Use the *Leaving Employment before Retirement Eligibility* checklist at peba.sc.gov/publications under *Life event checklists*.

Benefits administrators of participating employers, not PEBA, must offer the employee and his covered spouse and/or children COBRA enrollment information by letter, except if:

- The termination was due to non-payment of premiums;
- The termination was due to gross misconduct. Consult your legal counsel before making this determination; or
- The employee, whose spouse is also a covered employee or retiree, may apply for health, dental or vision on his spouse's coverage within 31 days of termination.

If the employee is eligible to retire

You must offer the retiring employee and his covered spouse and/or children COBRA enrollment information by letter, even though he is eligible for retiree insurance benefits.

Required COBRA notices

The required COBRA notices are available at peba.sc.gov/forms under the COBRA category.

Each COBRA notice includes an instruction sheet that summarizes the notification procedures for that notice. These instruction sheets are very helpful, so please be sure to read them before you proceed. Download the forms and enter the subscriber and COBRA information where prompted. Routinely check PEBA's website for updated forms.

Benefits administrators of participating employers, not PEBA, are responsible for completing and mailing these COBRA notices:

- Initial COBRA Notice and *Your Rights and Responsibilities under COBRA*;
- 18-month COBRA Notice and *Important Information about Your COBRA Continuation Coverage Rights*; and
- 36-month COBRA Notice and *Important Information about Your COBRA Continuation Coverage Rights*.

Retain a copy of the entire notice for the employee's file. See Important note for National Medical Support Notices (NMSN) below.

Mailing requirements for all COBRA notices

Follow the detailed instructions, available within each notice, for issuing the notice(s).

Send the notice via first-class mail to each covered employee and spouse. The notice to covered spouse is notification to all covered dependents. One notice to the home satisfies the requirement if the spouse and child(ren) live at the same address as the employee. No proof of receipt is required.

Hand delivery to the employee is **not** considered notice to a covered spouse or child(ren). A separate notice should be mailed to the spouse and child(ren). Employee must sign for receipt of notice if using hand delivery.

Important note for National Medical Support Notices (NMSN)

Do not retain copies of any NMSN dependent notices in the employee's file. This ensures the privacy of the NMSN dependent(s).

Initial COBRA Notice

First required notice

Benefits administrator sends this notice of the right to purchase temporary extension of group health, dental or vision coverage when coverage is lost due to a qualifying event.

The initial notification provides a broad summary of the COBRA law and procedures, outlines the obligations of employers and explains the rights and responsibilities of employees and their dependents, including the 60-day notification requirement. Federal law states the *Initial COBRA Notice* must be mailed within 60 days of effective date of coverage.

Send the Initial COBRA Notice when:

- A new employee elects health, dental, vision or a Medical Spending Account for himself and/or his spouse and child(ren);
- An employee adds a spouse or child(ren) due to a special eligibility situation; or
- Anyone (employee and/or dependents) newly covered at open enrollment.

Follow the detailed instructions, available within each notice, for issuing the notice(s).

Notification is not required if the employee, his spouse and children do not enroll in health, dental, vision or a Medical Spending Account.

If this notice has not been provided to your covered employees, spouse and child(ren), send a notice immediately.

You must review the employee file for coverage level information. If the employee is covered with dependent(s), carefully follow the notice instructions for how to complete and address the notice(s) and envelope(s).

60-day COBRA notification requirement for spouses and children

Spouses and children must meet this requirement to be eligible to continue coverage under COBRA.

Under COBRA, the employee, spouse or other covered family member must notify his benefits office within 60 days of the date when coverage would have been lost to be eligible to continue coverage under COBRA.

This rule applies to all spouses and children enrolled in health, dental and/or vision coverage.

If a qualifying event is not reported to the benefits office within 60 days of when coverage would have been lost, had it been reported in a timely manner, COBRA rights for that individual(s) are forfeited. In this situation, no COBRA coverage should be offered, and no second notification should be sent.

This 60-day requirement is included in the initial COBRA notice.

Procedures for determining COBRA eligibility

- Determine if a COBRA-qualifying event has occurred.
- Document the date you are notified of the event.
- Confirm the date the initial notice was mailed and that it included the 60-day notification requirement.
- Calculate the date of loss of coverage had the event been reported in a timely manner.
- Count 60 calendar days from the date determined to be the coverage loss date.
- If the qualifying event was reported within this 60-day period, offer COBRA; if not, do not offer COBRA.
- Document the file. If eligible, send Notice of COBRA Qualifying Event; if ineligible, use the COBRA Ineligibility Form for Dependents.

Example

Date of qualifying event: September 15, 2019	
Date BA notified of event	January 20, 2020
Date initial COBRA notice mailed	November 20, 1997
60-day notification language included in notice?	Yes
Date of coverage loss if reported timely	October 1, 2019
60 calendar days from date of coverage loss	November 29, 2019 (60 days from October 1, 2019)
Qualifying event reported within this period?	No
Action	Do not offer COBRA. Document file, using the *COBRA Ineligibility Form for Dependents*.

COBRA Qualifying Event Notice

Second required notice

Benefits administrator sends this notice to eligible qualified beneficiaries of their right to elect COBRA coverage when a qualifying event occurs.

The individual must be covered on the day before the qualifying event by health, dental and/or vision to continue coverage under COBRA. Each individual, including spouses and child(ren), covered under the plan is a qualified beneficiary and has independent election rights.

COBRA should **not** be offered to spouses or children who were dropped because of the Dependent Eligibility Audit.

After a qualifying event has occurred, eligible individuals should be notified of their rights to continue health, dental and/or vision coverage.

If the employee became eligible for Medicare within 18 months before the employee's termination of employment or reduction of hours, the maximum period of COBRA coverage for his covered spouse

and/or children is 36 months from the date the employee became eligible for Medicare. This is known as the *Medicare Entitlement Rule*.

Depending on the tobacco and e-cigarette use status before and whether that status has changed for the new COBRA subscriber, a new *Certification Regarding Tobacco and E-cigarette Use* form may need to be completed and attached to the *COBRA NOE*.

Qualified beneficiaries

A qualified beneficiary is an individual eligible to continue coverage if coverage is lost due to a qualifying event. He must be covered (under Health, Dental Plus, Basic Dental, State Vision Plan and/or MoneyPlus Medical Spending Account) on the day before the qualifying event.

- Includes a **covered employee**, the **covered spouse** of the covered employee or a **covered child** of the covered employee.

Each qualified beneficiary has independent rights to elect COBRA.

Who is a qualified beneficiary?

- Active and retired employees.
- Spouses and dependent children of employees or retirees.
- Newborns or children placed for adoption with the covered former employee or retiree, if added to COBRA coverage within 31 days of birth or adoption, or during open enrollment.

Two situations may occur during the COBRA coverage period that would cause a child, who was not covered at the time of the qualifying event, to gain the status of a qualified beneficiary. These are:

- A child born to, adopted by or placed for adoption with a *covered employee* during a period of COBRA coverage.
- A child receiving benefits pursuant to a Qualified Medical Child Support Order or a National Medical Support Notice, if the support order or notice requires the *covered employee* to provide coverage.

Qualified beneficiaries under COBRA are eligible to elect individual health plans if desired, but they must complete separate NOEs.

Who is not a qualified beneficiary?

- Individuals not meeting the definition of qualified beneficiaries who are added as dependents onto a qualified beneficiary's coverage during open enrollment or because of a special eligibility situation.
- Newborn or adopted children placed with individual on COBRA who is not the covered former employee or retiree.
- Non-resident aliens with no source of income in U.S.

Not every spouse or child who is added to coverage during the COBRA coverage period would be a qualified beneficiary, eligible to extend their COBRA coverage if a second qualifying event occurs, such as divorce. *Example*: If a subscriber on COBRA coverage gets married and adds his new wife to his coverage, she is *not* a qualified beneficiary and would not be eligible to extend her coverage to 36 months should the couple divorce one year later.

If a spouse or child is found not to be eligible for coverage due to an audit or other event, the individual is not eligible for COBRA coverage.

18-month COBRA qualifying events

Provide the 18-month notice when an employee:

- Leaves employment;
- Transfers;
- Retires; or
- Has a reduction of hours and is not in a stability period (full-time to part-time, strikes, layoffs and leave of absence). Note: For information about administering COBRA for an employee who goes on a leave of absence, see Page 56.

Extending COBRA coverage to 29 months

The Omnibus Budget Reconciliation Act of 1989 added a provision to COBRA that affects the 18-month continuation period. The intent is to provide additional coverage protection for disabled qualified beneficiaries.

If a qualified beneficiary is approved for Social Security disability benefits according to Title II or XVI of the Social Security Act, he is entitled to extend the 18 months of COBRA coverage to 29 months from the date of the qualifying event, so long as these criteria are met:

- The qualifying event must be the covered employee's **termination of employment or reduction of hours**;
- The qualified beneficiary must be determined under the Social Security Act to have been **disabled at any time before or during the first 60 days after loss of coverage**. It is the qualified beneficiary's responsibility to obtain the disability determination from the Social Security Administration;
- The qualified beneficiary **must notify the COBRA administrator of the Social Security disability determination *within 60 days after the latest of:***
    - The date of the Social Security disability determination;
    - The date of the qualifying event (i.e., the employee's termination of employment or reduction of hours);
    - The date that the qualified beneficiary loses (or would lose) coverage as a result of the qualifying event; or
    - The date that the qualified beneficiary is informed, through the initial COBRA notice, of the responsibility to provide the notice of disability determination and the procedures for providing such notice to the COBRA administrator.

The qualified beneficiary must notify the COBRA administrator of the Social Security determination **before the end of the 18-month period following the qualifying event** (i.e., the employee's termination of employment or reduction of hours).

The extension of coverage to 29 months is not limited to just the disabled qualified beneficiary. *It applies to all individuals who are qualified beneficiaries as a result of the same first qualifying event. This is true even if the disabled qualified beneficiary does not elect to continue or extend coverage under COBRA.*

If the disabled qualified beneficiary extends coverage, the COBRA administrator can increase the premium to 150 percent for all qualified beneficiaries during the extended 11-month COBRA period. If the disabled qualified beneficiary does not extend coverage, the COBRA premium remains 102 percent.

A qualified beneficiary, whose coverage is extended, must notify the plan administrator within 31 days if a final determination is made that he is no longer disabled. He should complete and submit to his COBRA administrator a *Notice to Terminate COBRA Continuation Coverage*.

Extending COBRA coverage to 36 months

A second qualifying event may occur during the 18- or 29-month period of coverage (i.e., divorce, child becomes ineligible).

In such a case, the 18- or 29-month period of coverage may be extended to 36 months, but only for those individuals listed on Page 80.

Second qualifying events must be reported within 60 days of the event and within the original 18- or 29-month period. The subscriber should complete and submit to his COBRA administrator a *Notice to Extend COBRA Continuation Coverage*, along with the documentation requested on the form. He does not need to complete a COBRA NOE.

No qualifying event can extend the maximum coverage period beyond 36 months from the date

of the first qualifying event, except for military leave.

Second qualifying events are:

- Death of former employee
  - The covered spouse and covered child(ren) are eligible for up to 36 months of continuation coverage.
- Divorce/legal separation
  - The covered spouse and covered child(ren) are eligible for up to 36 months of continuation coverage.
- Child(ren) becomes ineligible
  - The covered child(ren) who turns 26 during the original COBRA continuation period is eligible for up to 36 months of continuation coverage.
- Military leave.
  - The employee is eligible for up to 36 months of continuation coverage.
- The COBRA subscriber may complete a *Notice to Extend COBRA Continuation Coverage* if there has been a second qualifying event that may extend COBRA coverage. He should attach any documentation requested on the form.
- The completed form should be returned to his COBRA administrator.

COBRA Termination Notice

Third required notice

PEBA sends this notice directly to the qualified beneficiaries when COBRA continuation requirements have been met and COBRA coverage is ending (the end of the 18, 29 or 36 months of required continuation coverage). This notice is sent via first-class mail to the last known address.

The benefits administrator does **not** send this notice.

A Certificate of Creditable Coverage is mailed upon termination.

Other coverage may end COBRA eligibility

Eligibility for health, dental and/or vision coverage under COBRA may end sooner than the periods discussed earlier in this section. Eligibility will also end when:

- The subscriber or an eligible spouse or child(ren) enrolls in Medicare (Part A, Part B or both) *after* COBRA coverage is elected.
  - If the individual has Medicare *and then elects* COBRA, he can take COBRA for secondary coverage. Medicare will be primary.
- After the subscriber has elected COBRA, the subscriber or an eligible spouse or child becomes covered under other group coverage for which there is no exclusion or limitation for any preexisting condition that the individual may have.
  - If the individual *already* has the other coverage when he elects COBRA, he can have both. The plan that covers the subscriber as an employee will be primary to the plan that covers him as a spouse.

The loss of COBRA eligibility applies only to the person who enrolls in Medicare or other coverage. Covered persons who do not enroll in Medicare or other group coverage may continue their COBRA coverage as long as they are otherwise eligible.

To end COBRA coverage, the subscriber completes and submits to his COBRA administrator a *Notice to Terminate COBRA Continuation Coverage*, along with the documentation requested on the form.

COBRA election period

Once the qualifying event notification has been sent, each qualified beneficiary has a period of time during which to make the decision to elect COBRA continuation coverage.

The qualified beneficiary has 60 days after the date of loss of coverage or the date the notification of COBRA rights is sent (whichever date is later) to elect to continue coverage under COBRA.

- During this period, an employer cannot take any action to hurry an election or a waiver of COBRA coverage.

An election is deemed made on the date postmarked on the NOE that is sent to the COBRA administrator.

- If a qualified beneficiary signs a waiver of COBRA coverage, the waiver can still be revoked at any time during the 60-day election period.
- Once a qualified beneficiary has elected COBRA coverage, he cannot waive afterward, even if time remains in the 60-day election period.

Qualified beneficiaries who are enrolled under COBRA continue with the same health insurance plan. Exception:

- A qualified beneficiary may change *from* the Standard Plan *to* the Savings Plan. Keep in mind that any deductible amounts accrued under the previous plan will *not* carry over to the Savings Plan. A beneficiary who changes to the Savings Plan must meet the full deductible before benefits are payable.

Initial premium payment period

The qualified beneficiary is allowed 45 days from the date of election to make his initial payment as explained below. If the 45th day falls on a weekend or holiday, the first payment is due the following business day.

The initial payment must include the COBRA premiums back to the date of the loss of coverage.

Example

Qualifying event: Divorce	
Date of qualifying event	May 28
COBRA start date	June 1
COBRA election date	July 22
First payment due	September 5 If date falls on a weekend or holiday, the next business day.
First payment includes	COBRA premiums for June, July and August

COBRA coverage will not be activated and claims will not be paid until the initial 45-day premium payment is received.

To activate COBRA coverage immediately so benefits can be paid, the initial 45-day premium payment, as described above, must accompany the COBRA NOE. Exception:

- Optional employers collect the premium payment before submitting the COBRA NOE to PEBA.

If the amount due is not paid within this period, COBRA coverage can be terminated retroactively, and the subscriber may be liable for any benefits paid during the period.

Following the initial premium payment, subsequent payments are due on the 10th of the month for that month. COBRA subscribers have a 31-day grace period to pay.

- In the example above, the premium for September would be due September 10, and the subscriber has until October 10 to pay it. If the subscriber does not make a payment within the 31-day grace period, his coverage is terminated, and he loses all continuation rights under the plan.

Administrative fee for optional employers

PEBA charges optional employers a $3 per month administrative fee for COBRA subscribers. This administrative fee may not be passed along to the COBRA subscriber. See more information in the *Optional Employer Handbook*.

By law, the maximum premium the COBRA administrator can charge the subscriber is 102 percent of the total premium (employer and employee shares) charged to an active employee. There is one exception: when 18-month COBRA coverage is extended to 29 months, the COBRA administrator can charge 150 percent of the total premium for active employees (see Page 81).

Benefit changes

Qualified beneficiaries are entitled to the same rights as active employees. These rights include participating in open enrollment periods, changing plans, special eligibility situations and adding a newly acquired spouse or children.

COBRA procedures for the Medical Spending Account

IRS Code Section 125 allows an employee to continue his Medical Spending Account under COBRA if certain conditions are met. The Medical Spending Account can be continued only for the rest of the plan year. Employees may not re-enroll for the next year.

The subscriber must be enrolled in the Medical Spending Account at termination.

The subscriber must, on a timely basis, elect to maintain continuous contributions, on an after-tax basis to the Medical Spending Account.

The monthly administrative fee will be added to the amount due.

- COBRA rules allow an additional administrative fee for continuing the Medical Spending Account of two percent of the monthly amount in all cases, except disability. The fee is calculated and included with the payment.

Procedures at termination

- PEBA will send ASIFlex a file to report COBRA qualifying events.
- ASIFlex will then notify the participant of his COBRA rights and include a *COBRA Continuation Coverage Election Form*.
- The monthly contribution amount already will be filled in on the form.
- The notification will include information regarding when and how payments should be made.
- When ASIFlex receives the election form from the participant, ASIFlex will process the application and send payment coupons to the participant for future monthly payments. Remember that participants may continue only their Medical Spending Accounts and coverage through the end of the year.
- The participant has 45 days from the date the election is signed to make the initial payment.
- The initial payment must include the cost of the continuation coverage from the time the coverage would have otherwise terminated, up to the time he makes his initial payment.
- The monthly contribution amount and the amount of the initial payment will be included in the payment coupons that will be sent to the participant.
- If no payment is received within 45 days, the individual will lose all continuation rights under the plan.
- Subsequent payments are due by the first day of the month coverage is provided. If payments are made on or before the due

date, coverage will continue without any break.

- **There is a 31-day grace period for payment. Payments must be postmarked by this date, and if ASIFlex does not receive payment by the end of the grace period, coverage will end as of the last paid-through date.**

Benefit administrators with MoneyPlus COBRA questions may call ASIFlex at 833.SCM.PLUS. Employees should call ASIFlex's at 833.SCM.PLUS.

Affordable Care Act reporting requirements

Employers who participate in the State Health Plan have certain requirements under the Affordable Care Act. Employers must provide subscribers with proof of health coverage by issuing forms to subscribers. Each year, the IRS determines the date by which employers must send the forms to subscribers. Learn more on Page 62.

COBRA quick reference

Action type	Required COBRA notice
New hire	Initial Notification
Special eligibility situations *(adding someone to coverage):* • Marriage • Birth • Adoption/placement for adoption • Gaining custody • Loss of other coverage	Initial Notification
Open enrollment *(adding someone to coverage):* • Employee • Spouse • Child(ren)	Initial Notification
Open enrollment *(dropping someone from coverage):* • Employee • Spouse • Child(ren)	No notice required, unless due to a qualifying event (separation, divorce or child becomes ineligible).
Gain of other coverage	No letter required
Legal separation	36-Month Qualifying Event Notice
Divorce	36-Month Qualifying Event Notice
Child becomes ineligible	36-Month Qualifying Event Notice
Transfers	Losing employer should send the 18-month Qualifying Event Notice. Gaining employer should send the Initial Notification.
Leaves employment (for reasons other than gross misconduct or non-payment of premiums)	18-month Qualifying Event Notice
Retires	18-Month Qualifying Event Notice
Working hours reduced (not in a stability period)	18-Month Qualifying Event Notice

Retiree subscribers

Retiree subscribers

Requirements for retiree insurance

Eligibility for retiree group insurance is not the same as eligibility for retirement. Determining retiree insurance eligibility is complicated, and only PEBA can make that determination.

PEBA recommends an employee review the requirements for retiree group insurance in the Retiree group insurance chapter of the IBG before he confirms his retirement date. You may also share the retiree insurance flyers, available at peba.sc.gov/nyb, with employees.

In addition to qualifying for retirement, an employee's last five years of employment must be served consecutively in a full-time, insurance-eligible permanent position with an employer that participates in the State Health Plan to qualify for retiree insurance.

PEBA insurance benefits **cannot** confirm eligibility over the telephone. If an employee's anticipated retirement date is **within 90 days**, direct him to submit an *Employment Verification Record* with a *Retiree NOE*.

If an employee's anticipated retirement date is **three to six months away**, direct him to submit an *Employment Verification Record* and PEBA will provide confirmation of his eligibility.

PEBA will not confirm eligibility for retiree insurance **more than six months** before an employee's anticipated retirement date.

Assisting an eligible retiree

Retiree packet information

The *Retiree Packet*, available at peba.sc.gov/forms, is a comprehensive packet that includes the retiree insurance flyers, *Employment Verification Record*, *Retiree NOE* and helpful information for retirees.

Administrative information

PEBA acts as the benefits administrator for retirees, except retirees of optional employers. Benefits administrators serve as the main point of contact for retirees of optional employers.

Retirees do not have to be receiving a retirement check from PEBA to be eligible for retiree insurance. However, they must be eligible for a retirement check and must meet the retiree insurance eligibility requirements explained in the Retiree group insurance chapter of the IBG.

Retirees continue to use the same health and dental ID cards (if they do not change plans) and the same *Insurance Benefits Guide*.

PEBA will send open enrollment information to retirees at their last known address in PEBA's records.

For optional employers only

An optional employer does not have to participate in PEBA-administered retirement plan for its eligible retirees to participate in the State Health Plan. Eligibility is determined as if the retiree was a member of the South Carolina Retirement System.

Benefits administrators serve as the main point of contact for retirees of optional employers.

For PEBA to determine eligibility, the *Employment Verification Record* must be verified and signed by the benefits administrator.

Optional employers must offer all eligible retirees the entire package of state insurance benefits for which they are eligible and must allow retirees to refuse all or any part of the benefits package.

Optional employers are billed for all retirees and must collect all premiums for their retirees.

An optional employer can choose the amount, if any, it wishes to contribute toward health and dental coverage for its eligible retirees. If your optional employer wants to make contributions, you must develop your own premium tables by adjusting the non-funded retiree premiums in the

IBG to reflect your optional employer's contribution.

Notes regarding academic retirees

If active employee insurance premiums are deducted on a prorated scale to cover the summer months, you must refund any overpaid premiums that result when a teacher or academic employee retires after the spring semester.

Advanced deduction of premiums does not constitute continuous coverage throughout summer months, unless the employee is actively working on a full-time basis during that time.

Important retirement information

Health insurance

The same certification and documentation required of active subscribers, spouses and children applies to retirees and their spouses and children (i.e., eligibility documentation, spouse is a state group employee/retiree, spouse lost coverage, incapacitated child, etc.).

If both the retiree and spouse are covered retirees and both are enrolled in the same health plan, the family deductible will apply.

- Both retirees must enroll individually. Some exceptions may apply.
- Only one parent can enroll a child. However, one parent can cover the child under health and the other parent cover the child under dental, for example.

When the retiree becomes eligible for Medicare

Applies also to covered spouses and children

Due to age:

- PEBA will notify the retiree, in advance of his 65th birthday that his coverage will change automatically to the Medicare Supplemental Plan when he turns age 65.
- Advise your retirees to enroll in Medicare Parts A and B when they become eligible to have optimal coverage.
- Eligibility for the GEA TRICARE Supplement Plan will end.
- Retirees must submit a copy of their Medicare card to PEBA.

Due to disability/before age 65:

- The retiree or covered spouse or child must notify PEBA within 31 days of becoming eligible for Medicare due to disability or due to end-stage renal disease and submit a copy of his Medicare card to PEBA.
- When an individual begins dialysis for end-stage renal disease, he becomes eligible for Medicare three months after beginning dialysis. At this point, he begins a "coordination period" of 30 months. During this time, his coverage through the State Health Plan remains primary. When the coordination period ends, Medicare becomes primary. The coordination period applies whether the subscriber is an active employee, retired, a survivor or a covered spouse or child, and regardless of whether the subscriber was already eligible for Medicare due to another reason, such as age.
- Eligibility for the GEA TRICARE Supplement Plan will end.

Medicare Part D

State Health Plan retirees, survivors, COBRA subscribers and their dependent spouses and children enrolled in Medicare are eligible for Express Scripts Medicare, a group-based, Medicare Part D Prescription Drug Plan (PDP). PEBA has determined that most subscribers covered by the Medicare Supplemental Plan or the Standard Plan will be better served if they remain enrolled in this Medicare Part D plan sponsored by PEBA.

- Each fall, before Medicare's annual enrollment period, PEBA is required to send a notice to subscribers who are eligible for Medicare notifying them of their options.

- If a Medicare-eligible subscriber or his eligible spouse or child enrolls in a Medicare Part D plan not sponsored by PEBA, he will lose his prescription drug coverage through his plan with PEBA, and his health insurance premiums will not decrease.
- Most individuals enrolled in Medicare who have coverage through PEBA should not enroll in a separate Medicare Part D plan.
- Under Part D, the federal government offers a program to help pay monthly premiums and a program to help pay copayments/coinsurance for people with limited resources. To apply for limited income assistance, individuals can complete an application online at www.socialsecurity.gov or call the Social Security Administration at 800.772.1213.

Medicare Supplemental Plan
For Medicare-eligible retirees enrolled in the Medicare Supplemental Plan:

- Claims will be paid according to the Standard Plan provisions for covered family members who are not eligible for Medicare.
- The private duty nursing deductible starts with the effective date of the Medicare Supplemental Plan, even if the yearly deductible under the previous plan (Standard Plan, etc.) has already been met.

Dental insurance

The retiree group dental coverage is the same as the active group dental coverage. The retiree may elect dental coverage, even if he refuses health coverage.

Vision insurance

The State Vision Plan coverage is the same as the active group vision coverage.

- The retiree may elect the State Vision Plan, even if he refuses health coverage.

Life insurance

At retirement, the employee may continue or convert his Optional Life coverage. He may convert his Basic Life, Dependent Life-Spouse and/or Dependent Life-Child coverage to an individual whole life policy.

MetLife will mail to the retiree a conversion/continuation packet via U.S. mail three to five business days after MetLife receives the eligibility file from PEBA. The eligibility file is created from terminations submitted to PEBA by the employer.

To continue or convert coverage, the retiree must follow the instructions in the packet from MetLife. Coverage must be continued/converted within 31 days of the date coverage is lost due to approved retirement or approved disability retirement.

- Premiums for continued or converted coverage are due by the payment due date.
- If the individual is billed monthly, his policy will be canceled 60 days from the billing date of the first unpaid or partially paid bill. Approximately 10 days after the first bill's due date, MetLife will bill again. The due date will be 21 days later. If neither of these bills are paid in full, the individual's coverage will cancel on the 60th day.
- If the individual is billed quarterly, semi-annually or yearly, his policy will be canceled 60 days from the billing date of the first unpaid or partially paid bill. The individual will not receive another bill or a reminder notice.

Death benefits within 31 days after retirement

If a retiree, his spouse or his child dies within the 31-day period in which he is entitled to have a conversion and/or continuation policy issued, the amount of group life insurance the retiree, his spouse or his child was eligible to continue or convert will be paid to the designated beneficiary. The benefits administrator completes and submits

the claim to MetLife. More on filing life insurance claims is in the Claims and appeals chapter.

If death occurs after the 31-day period, benefits will not be paid, unless the retiree submitted an application and paid the premium for the conversion/continuation.

In the case of a living benefit, the remaining percentage can be continued through the continuation or conversion provision, if the employee is retiring due to service or disability. If the employee is not retiring due to service or has not been approved for disability by The Standard or PEBA, the remaining percentage can be converted. Refer to the IBG for information on the living benefit and continuation of life insurance in retirement.

Basic Life

Within 31 days of retirement, Basic Life coverage may be converted to an individual whole life policy through MetLife. The retiree should follow the instructions in the packet he receives from MetLife if he is interested in converting this coverage.

Optional Life

Within 31 days of retirement, Optional Life coverage may be continued as a term policy with no cash value; or converted to an individual whole life policy through MetLife.

The minimum amount of coverage that can be continued as a term policy is $10,000.

The retiree should follow the instructions in the packet he receives from MetLife.

The subscriber may also choose to split his coverage and continue a portion as a term policy and convert a portion to an individual policy. If the retiree does not continue his coverage, he *cannot* re-enroll later (e.g., during open enrollment or if a special eligibility situation occurs). You may want to make a note in his file if he does not want to continue or convert this coverage. Accidental death and dismemberment coverage is available only to active employees; it cannot be continued into retirement.

Retirees with questions about their life insurance coverage may call MetLife at 888.507.3767.

Dependent Life

Within 31 days of retirement, Dependent Life coverage may be converted to an individual whole life policy through MetLife.

If the retiree does not convert coverage, he *cannot* re-enroll his spouse or children later (e.g., during open enrollment). He also cannot add a new spouse or child to Dependent Life coverage later if a special eligibility situation occurs. You may want to make a note in his file if he does not want to convert this coverage.

- The spouse or child must be covered when the employee leaves employment.
- The 31-day rule applies to converting life insurance into retirement.

The retiree should follow the instructions in the packet he receives from MetLife.

Long term disability

Basic Long Term Disability and Supplemental Long Term Disability may not be continued or converted to an individual policy at retirement.

MoneyPlus

Flexible spending accounts

Generally, a retiree cannot continue to participate in MoneyPlus in retirement, except:

- A Medical Spending Account participant may *continue coverage on an after-tax basis*, under COBRA, through the end of the plan year. As an alternative, a terminated retiree can waive COBRA coverage and elect to prepay all remaining contributions on a pretax basis in order to continue coverage through the end of the plan year. Otherwise, the retiree cannot use his Medical Spending Account after he leaves employment and cannot access any remaining funds.
- Refer to the IBG for specific eligibility information regarding the Pretax Group

Insurance Premium feature and the Dependent Care and Medical Spending Accounts.

Health Savings Account

If a retiree is not eligible for Medicare and is continuing coverage under the Savings Plan or other high deductible health plan, he may continue to contribute to his Health Savings Account (HSA).

- A retiree cannot contribute to his HSA on a pretax basis through MoneyPlus.
- A retiree can contribute directly to Central Bank, custodian for the MoneyPlus HSA, or to another HSA custodian.

Assisting a new retiree with enrollment

Eligible retirees may enroll in and add or drop their spouse or children from health, dental and/or vision coverage within 31 days of the date of retirement.

Use the *Service retirement* checklist at peba.sc.gov/publications under *Life event checklists*.

Completing the *Retiree NOE*

Refer to the instructions on the back of the *Retiree NOE* for details about completing the form. Use only this form when enrolling a retiree.

- An *Active NOE* with "Retiree" written across the top will be rejected by PEBA.

Important reminders

Eligibility
Indicate the type of retiree and provide the years, months and days of service. Attach an *Employment Verification Record* if the form has not previously been sent to PEBA, to determine eligibility.

If applicable, check whether there is a 5-14-year, 15-24-year, or age 55/25-year and corresponding end date.

Benefits administrators of optional employers must verify retirement eligibility for their employees and sign the *Retiree NOE.*

Coverage
The retiree must select coverage and if refusing coverage, must check *Refuse*.

Medicare
If the retiree or any family members are eligible for Part A or B of Medicare, this section must be completed. A copy of the Medicare card(s) must be provided to PEBA.

Certification and authorization
The retiree should read this section, then sign and date.

If the tobacco and e-cigarette use status has changed for the retiree and/or his dependents, complete a *Certification Regarding Tobacco or E-cigarette Use* form and attach it to the Retiree NOE.

Changing coverage in retirement

Regular rules for coverage changes during open enrollment apply.

If a retiree does not pay his complete bill, **all of his coverage** will be canceled effective the last day of the month in which he paid his premiums in full. This includes all premiums for health insurance including the tobacco and e-cigarette use premium, Dental Plus, Basic Dental and the State Vision Plan. Benefits that require no retiree contribution (i.e., Basic Dental) are included in this cancellation policy. The retiree may re-enroll in coverage within 31 days of a special eligibility situation or during open enrollment.

Retiree returns to work

If a retiree, who is covered under the state retiree group, returns to an insurance-eligible position, he must return to active coverage status or refuse all PEBA coverage. If the retiree, his eligible spouse or any of his children are eligible for Medicare, he must be offered active group coverage. See Medicare on Page 92 for additional information. There is one exception to this rule. Retirees who are not eligible for Medicare and who retired from an

employer that does not participate in the state's Retiree Health Insurance Trust Fund can remain on retiree coverage if they return to work in an insurance-eligible position.

A part-time teacher who is not eligible for Medicare may choose to stay on retiree group insurance coverage.

Life insurance

Retirees returning to work should review their current life insurance coverage and needs carefully before deciding how much coverage they need.

Optional Life

If the retiree continued his Optional Life (OL) coverage at retirement, he must decide whether to keep his continued coverage or cancel it and enroll in OL as an active employee.

- If the retiree elects to enroll in OL coverage as an active employee, he must contact MetLife to cancel his continued retiree coverage due to his return to active status.
- A return-to-work retiree cannot keep his continued policy and elect OL coverage as an active employee.

If the retiree converted his OL coverage at retirement, he may keep the converted policy and enroll in OL as an active employee. In the event of a claim, both policies would pay, provided the premiums are paid.

Dependent Life

Since Dependent Life (DL) coverage may be converted only at retirement, if the retiree returns to work and enrolls as an active employee, he is not required to drop any converted DL coverage to enroll his spouse and/or children in DL as an active employee.

Medicare

If a return-to-work retiree, including a part-time teacher, his eligible spouse or any of his children are eligible for Medicare, he can:

- Change to one of the active group plans. Medicare will be the secondary payer to the active group coverage. He must notify Social Security that Part B will be the secondary payer to his active coverage; or
- Refuse PEBA health insurance coverage altogether (he must disenroll) and keep his Medicare coverage. However, you cannot offer an incentive for the employee to refuse active group coverage.

When the return-to-work retiree leaves active employment and his active group coverage is terminated, he will be eligible to return to retiree group coverage. He must submit a *Retiree NOE* to return to the state retiree group within 31 days of termination.

- In addition, he must notify Social Security that he is no longer covered under an active group, so Medicare can become his primary payer or so he can re-enroll in Medicare Part B during the special enrollment period, if Part B was canceled. The cost of Part B will not increase. Call the Social Security Administration at 800.772.1213 with questions.

Affordable Care Act reporting requirements

Employers who participate in the State Health Plan have certain requirements under the Affordable Care Act. Employers must provide subscribers with proof of health coverage by issuing forms to subscribers. Each year, the IRS determines the date by which employers must send the forms to subscribers. Learn more on Page 62.

Survivors

Survivors

General rules about survivor coverage

A survivor is a spouse or child(ren) on the coverage of an active employee or retired subscriber who has died.

A survivor can continue health, dental and/or vision benefits as long as he is eligible.

If Dependent Life-Spouse and/or Dependent Life-Child coverage was in place when the subscriber died, that coverage can be converted within 31 days of the subscriber's date of death.

If survivor was not covered at the time of subscriber's death

A surviving spouse or child(ren), who is not enrolled when the covered subscriber dies, is not eligible for coverage as a survivor.

The survivor will not be eligible to enroll later during open enrollment, nor will he be eligible to enroll due to a special eligibility situation.

If survivor was covered at the time of subscriber's death

A surviving spouse or child(ren), who is enrolled in health, dental and/or vision coverage when the subscriber dies, is eligible to continue that coverage as a survivor.

The survivor can continue only the coverage he had at the time of the subscriber's death. He may change health plans within 31 days of gain of coverage as a survivor.

The survivor may add other coverage during open enrollment or within 31 days of a special eligibility situation such as loss of other coverage.

If the covered surviving spouse or covered child(ren) terminates health, dental **and** vision coverage, he loses his eligibility for coverage as a survivor. He will no longer be eligible to re-enroll during open enrollment, nor will he be eligible to enroll otherwise due to a special eligibility situation.

If the covered surviving spouse or covered child(ren) terminates health, dental **or** vision coverage, but he still retains at least one of the other coverages, he keeps his eligibility for coverage as a survivor. He may re-enroll in the other coverage(s) during open enrollment or when a special eligibility situation occurs.

A surviving spouse may add eligible child(ren) to coverage during open enrollment or when a special eligibility situation occurs.

Survivors of deceased active employees are classified as survivor subscribers under the retiree group.

Assisting a survivor

Use the *Death of a covered employee* checklist at peba.sc.gov/publications under *Life event checklists*.

If applicable, notify PEBA retirement benefits regarding the death and any refund or monthly benefit that may be due.

Complete an *Active Termination Form*, *Retiree NOE* or *Survivor NOE* (depending upon the status of the deceased) to terminate the coverage as soon as the death is confirmed, and forward it, along with a copy of the death certificate/documentation, to PEBA insurance benefits immediately.

If the deceased was killed in the line of duty, attach verification to the NOE.

If the deceased was an active employee subscriber

If the subscriber was enrolled in Optional Life and/or enrolled in a health plan, thus has Basic Life coverage, file for life insurance with MetLife. See Page 97 for more information.

If the subscriber was enrolled in Long Term Disability and receiving benefits at the time of death, call The Standard to report the death for any potential benefits payable to eligible survivors.

- Any BLTD benefits remaining unpaid will be paid to the employee's estate.

- Any SLTD benefits remaining unpaid will be paid to the person(s) eligible to receive the survivor benefit that is defined in the SLTD policy. In case there are no eligible survivors as defined in the SLTD policy, survivor benefits would not be paid, and any SLTD benefits remaining unpaid would then be paid to the employee's estate.

MoneyPlus Medical Spending Accounts (MSA) and Dependent Care Spending Accounts (DCSA) are not refundable to the survivor. These accounts are terminated effective the date of death of the subscriber, unless the IRS-qualified spouse, child(ren) or beneficiaries elect to continue the MSA under COBRA through the end of the plan year.

If the subscriber had a MoneyPlus Health Savings Account (HSA), advise the survivor/beneficiary to contact Central Bank to settle the account. Central Bank will require proof of death for the deceased and identification for the beneficiary.

Procedures to continue coverage as a survivor

You must notify survivors about enrollment, cost of premiums, premium collection, coverage changes and terminations.

When PEBA receives the termination, PEBA will notify any covered survivor(s) that health coverage may be continued at no cost for one year (if eligible for the premium waiver) or by paying survivor premiums.

A *Survivor NOE* must be completed within 31 days of the subscriber's date of death. If, as a result of the death, the tobacco and e-cigarette use status for the survivor has changed, complete and attach a *Certification Regarding Tobacco or E-cigarette Use* form.

The survivor will receive new ID cards with a new benefits ID number (BIN). See also Which SSN/BIN to use for claims on Page 97.

PEBA will bill for continuation of dental and vision coverage if the survivor was covered and while the survivor is on a health premium waiver.

Optional employers are responsible for premium collection.

The survivor may pay premiums:

- Through deduction from a monthly PEBA retirement benefit check;
- By automatic bank draft; or
- By direct billing.

For any child(ren) covered by the deceased subscriber, if both parents were covered as active employees or retirees:

- **Health**: Add child(ren) to the surviving parent's health plan within 31 days of the ending date of the premium waiver.
- **Dental**: Add child(ren) to the surviving parent's dental plan within 31 days of the loss of coverage under the deceased's plan.
- **Vision**: Add child(ren) to the surviving parent's State Vision Plan within 31 days of the loss of coverage under the deceased's plan.

Premium waiver rules

A spouse and/or child(ren) must be enrolled in the State Health Plan, under the deceased employee's or employer-funded retiree's coverage, at the time of death to be eligible for coverage and the one-year waiver of premium for health insurance.

The waiver of health premium is effective the day after the date of death.

The premium waiver applies only if there was an employer premium contribution. This includes survivors of employees who work at least 20 hours a week, if the employer has elected the 20-hour threshold.

Survivors of deceased permanent, part-time teachers are not eligible for the premium waiver.

Optional employers may elect, but are not required, to waive the health premiums for survivors of retirees.

Survivors not eligible for the waiver may continue coverage by paying the full survivor premiums. Refer to the IBG for additional information on survivor coverage.

A surviving spouse is not entitled to a premium waiver if he feloniously or intentionally kills his active or retired spouse.

After the one-year waiver, survivors must pay the full cost to continue health coverage.

- *Exception:* If the deceased was killed in the line of duty while working for a participating employer, the surviving spouse or child(ren) may continue coverage, if he is eligible, at the employer-funded rate after the waiver ends. Optional employers may elect, but are not required, to fund this survivor coverage. Survivors not eligible for employer-funded premiums may continue coverage by paying the full survivor premiums.

There is no premium waiver for Dental Plus, Basic Dental or the State Vision Plan.

- *Exception:* If the deceased was killed in the line of duty while working for a participating employer, the dental premium of a surviving spouse or child(ren) will be waived for the first year after the employee's death.

All policies and procedures apply to survivors during the premium waiver period (i.e., changes due to family status changes, open enrollment, gaining coverage as an employee of a participating employer, etc.).

PEBA notifies survivors when the waiver period ends and when plan policies and procedures change. Optional employers receive a copy of this notification sent to survivors.

Survivors may drop health coverage within 31 days of the waiver end date. Otherwise, they must wait until open enrollment or a special eligibility situation.

Which SSN/BIN to use for claims

Continue to file claims for services provided to the deceased subscriber under his SSN or benefits ID number (BIN).

Effective the day after the date of death, the BIN for the surviving spouse and child(ren) is the surviving spouse's SSN or BIN, if the surviving spouse is covered. Otherwise, a BIN will be generated for the surviving spouse.

If survivor coverage is for child(ren) only, the BIN is the SSN or BIN of the youngest child, unless Medicare covers one of the children. Then, the BIN is the SSN or BIN of the child with Medicare. A BIN will be generated for the youngest child or the child with Medicare coverage, whichever is applicable.

New ID cards with the new BIN will be issued to the survivor(s).

For any child(ren) covered by the deceased subscriber, if both parents were covered as active employees or retirees:

- **Health**: During the waiver period, if applicable, claims should be filed using the SSN or BIN of the child. If there is more than one child, this would be the BIN of the youngest child.
- **Dental**: Dental claims should be filed using the surviving parent's SSN or BIN.
- **Vision**: State Vision Plan claims should be filed using the surviving parent's SSN or BIN.

Optional Life benefits for survivors

Once MetLife receives the completed Life Insurance claim and required documentation, MetLife will determine eligibility and pay the life insurance

proceeds and any accidental death and dismemberment benefits, if applicable, such as:

- Accidental Death Benefit (based on the death certificate);
- Seat Belt and Air Bag benefit (based on the police report and/or accident report);
- Dismemberment benefits (based on the accident report);
- Felonious Assault Benefit (based on the police report/death certificate);
- Day Care Benefit (paid to beneficiaries, younger than age 7, who are enrolled in day care); and
- Dependent Child Education Benefit (paid to qualified beneficiaries).

MetLife also offers legacy planning resources and beneficiary financial counseling. Share the *MetLife Advantages* flyer available at peba.sc.gov/nyb.

The subscriber may assign benefits to a third party, such as a funeral home. However, MetLife will not be bound by an assignment of the certificate or of any interest in it unless it is made as a written statement, and the subscriber files the original instrument or a certified copy with MetLife's home office, and MetLife sends the subscriber an acknowledged copy. For more information, contact MetLife or see the IBG.

More information on life insurance claims is in claims and appeals section, beginning on Page 120.

When survivor coverage ends

Spouse

The surviving spouse's eligibility to continue health, dental and/or vision coverage as a survivor ends upon remarriage. Survivor coverage ends the first of the following month.

Continuation of coverage under COBRA must be offered. The 36-month COBRA continuation period starts when eligibility for survivor coverage ends, regardless of when the survivor notifies his COBRA administrator. *Example*: Surviving spouse remarries but fails to notify his COBRA administrator for 12 months. He is thus eligible for COBRA coverage only for the remaining 24 months.

Gaining eligibility through participating employer

Eligibility for survivor coverage ends if a surviving spouse or child(ren) becomes eligible for coverage as an active employee with a participating employer. He cannot remain on survivor coverage and must enroll as an active employee.

If the survivor is on waiver status, he must pay the employee share of the premium, unless he is the survivor of an employee who was killed in the line of duty. He may return to survivor coverage when he leaves employment or continue coverage as a retiree, if eligible. He must enroll in survivor or retiree coverage within 31 days of when his active coverage ends. The remainder of the waiver period would not apply.

Any covered child who is not employed with a participating employer may remain on the waiver until it ends.

Children

A child may continue coverage until no longer eligible. Coverage ends the first of the following month after he becomes ineligible.

Continuation of coverage under COBRA must be offered. The 36-month COBRA continuation period starts when eligibility for survivor coverage ends, regardless of when the survivor notifies his COBRA administrator. *Example*: Surviving child becomes eligible for employer-sponsored group health coverage but fails to notify his COBRA administrator for 12 months. He is thus eligible for COBRA coverage only for the remaining 24 months.

Spouses and children

Spouses and children

Spouses: special eligibility requirements and changes in status

The subscriber is required to submit documentation to enroll a spouse as a dependent. If he fails to submit the required documentation, the dependent will be removed from coverage.

Any documentation that is in a language other than English must be completely translated into English and should be certified with a letter of accuracy from the translator.

The eligibility of a spouse is subject to review by PEBA.

In general, an eligible spouse may be added to coverage within 31 days of the special eligibility situation. Otherwise, a spouse may be added to coverage during open enrollment.

Ineligible spouses must be dropped from coverage within 31 days of the event that makes them ineligible for coverage.

Details and exceptions are outlined in each of the situations that follow.

Both spouses employed by participating employers

If legal spouses are employed by participating employers and eligible for coverage as employees, neither may be covered as a dependent spouse.

When a spouse gains eligibility with a participating employer, even if the spouse refuses coverage, he may not continue to be covered as a dependent.

A spouse is not required to carry the same health coverage. However, family deductibles will not apply unless the spouses elect the same health plan.

Spouses cannot cover the same child(ren) under the same benefit (health, dental, vision, Dependent Life).

Spouse gains eligibility as an employee of a participating employer

When a spouse gains eligibility as an employee, his coverage as a dependent must be dropped.

The effective date to drop a spouse as a dependent is the date the spouse's employee coverage begins.

- *Exception*: If a spouse goes to work as a part-time teacher with a participating employer, he may be covered as an employee or a spouse, but not both.

Spouse is retiree subscriber

A legal spouse who is also an employer-funded retiree is not eligible for coverage as a dependent.

Spouse gains eligibility as a retiree subscriber

When a spouse gains eligibility as a retiree, his coverage as a dependent must be dropped.

The effective date to drop a spouse as a dependent is the date the spouse's retiree coverage begins.

Marriage

Use the *Adding a dependent due to Marriage* checklist at peba.sc.gov/publications under *Life event checklists*.

The eligible employee may enroll himself, existing eligible dependents, his new spouse and new stepchildren in health, dental and/or vision coverage within 31 days of date of marriage.

- If the employee is already enrolled in health, he may change plans if he is adding his spouse or stepchild to health.

The effective date of coverage is the date of marriage for health, dental and vision coverage.

The eligible employee may add Dependent Life-Child, Dependent Life-Spouse ($10,000 or $20,000 without evidence of insurability) and Optional Life (up to $50,000 without evidence of insurability) within 31 days of date of marriage.

Dependent Life-Child coverage begins the first of the month after the date of the request.

Optional Life and Dependent Life-Spouse coverage begins the first of the month following the date of the request if the employee is actively at work.

- If not actively at work, the effective date is the first of the month following the return to work.

The eligible employee may be able to make changes to his Medical Spending Account or Dependent Care Spending Account.

The eligible employee must be on the plans or added with the spouse and/or child(ren).

Documentation
A marriage license or Page 1 of the employee's latest federal tax return if filing jointly is required to add a spouse.

A long-form birth certificate showing the name of the natural parent plus proof natural parent and subscriber are married is required to add a stepchild.

Note about premiums
If the employee is enrolled in the MoneyPlus Pretax Group Insurance Premium feature, premiums must be paid post-tax for retroactive coverage back to the date of marriage. Premiums may be paid pretax beginning the first of the month following the date of the request.

Spouse of foreign national employee

Add to coverage

A legal spouse of an eligible foreign national employee may be added to health, dental, vision and Dependent Life coverage within 31 days of arrival in the U.S.

A copy of the visa/visa stamp, showing the arrival date, and a copy of the marriage license are required to add the spouse as a dependent.

The effective date of coverage is the date the spouse entered the U.S.

Drop from coverage

A spouse of an eligible foreign national employee may be dropped from coverage within 31 days of departure from the U.S.

A copy of the visa/visa stamp, showing the departure date, is required to drop the spouse.

The effective date is the date the spouse left the U.S.

Separated spouse

A separated spouse may remain on health, dental, vision and/or Dependent Life-Spouse until the divorce is final. No documentation is required to continue coverage during separation.

Enrolled in Pretax Premium

Subscribers who are enrolled in the MoneyPlus Pretax Group Insurance Premium may **not** drop coverage for a separated spouse during the plan year, regardless of court order. However, a court could order the separated spouse to pay the subscriber for his share of the premiums instead. Subscribers enrolled in MoneyPlus must wait until open enrollment, until the divorce is finalized or until another special eligibility situation occurs to drop a separated spouse.

A copy of a court order signed by the judge is required. The order must state that the divorce is in progress.

The subscriber has 31 days from the date of the court order's date stamp from the Clerk of Court to drop the separated spouse.

If the subscriber is dropping the separated spouse from health, dental or vision coverage, he must drop the separated spouse from all three programs. He may drop or keep Dependent Life-Spouse.

The effective date is the first of the month after the date of the request on the change.

The subscriber may enroll in or increase Optional Life coverage up to $50,000 without evidence of insurability or cancel or decrease his Optional Life coverage. To do so, an employee must submit an

NOE to his benefits administrator within 31 days of the court order date. Changes to Optional Life coverage begin the first of the month following the date of the request if the employee is actively at work. If not actively at work, the effective date is the first of the month following the return to work.

If the subscriber fails to drop the separated spouse within 31 days of the date on the order, he must wait until open enrollment, until the divorce is finalized or until another special eligibility situation occurs to drop a separated spouse.

Reconciliation

Reconciliation is not a special eligibility situation. If a separated couple reconciles:

- The deleted spouse and/or children must wait until the next open enrollment period to be reinstated for health and State Vision Plan coverage.
- Dental coverage may be reinstated only during the next open enrollment period of an odd-numbered year or within 31 days of a special eligibility situation.
- The spouse may re-enroll in Dependent Life-Spouse at any time by providing evidence of insurability and being approved by MetLife.

Former spouse/divorce

Use the *Dropping a dependent due to Divorce* checklist at peba.sc.gov/publications under *Life event checklists*.

When a divorce is final, the subscriber must drop the former spouse from all benefits within 31 days of the divorce.

A copy of the entire divorce decree must be submitted to confirm the drop in coverage.

The effective date is the first of the month after the divorce becomes final.

- Exception: If the subscriber fails to drop the former spouse within 31 days of the divorce, the effective date will be the first of the month after the request is made.

The subscriber may enroll in or increase Optional Life coverage up to $50,000 without evidence of insurability.

The subscriber may be able to make changes to his Medical Spending Account or Dependent Care Spending Account.

Required to cover former spouse by divorce decree or court order

If a divorce decree or court order requires a subscriber to continue to cover a former spouse under the State Health Plan, the former spouse is required to have his own policy at the full cost of the premium. The subscriber is thus permitted to cover a current spouse as a dependent under his policy. The active employee subscriber is eligible to participate in the MoneyPlus Pretax Group Insurance Premium feature.

A former spouse should enroll using the *Former Spouse NOE* within 31 days of the date the court order or divorce decree is signed.

A copy of the entire divorce decree or court order, signed by the judge, must be included.

The divorce decree or court order must state that the subscriber is directed to provide insurance for the former spouse.

The effective date of former spouse coverage is the first of the month after the divorce becomes final.

Death of covered spouse

Use the *Death of a covered dependent* checklist at peba.sc.gov/publications under *Life event checklists*.

Upon the death of a covered spouse, the spouse must be dropped from coverage within 31 days of the date of death.

The effective date is the day after the spouse's date of death.

- Exception: If the subscriber fails to drop the spouse within 31 days of the death, the request to change the level of health, dental, vision and Dependent Life, if

applicable, may be changed retroactively, up to 12 months.

The subscriber may decrease or drop his Optional Life coverage within 31 days of his spouse's death.

Dependent Life-Spouse coverage

Eligibility requirements

The employee is the beneficiary for proceeds from Dependent Life-Spouse insurance. Spouses enrolled in Dependent Life are covered for Accidental Death and Dismemberment benefits. They are eligible for the Seat Belt and Air Bag benefit, Child Care benefit and Dependent Child Education benefit.

The employee may enroll his spouse in Dependent Life-Spouse coverage within 31 days of initial eligibility or within 31 days of loss of other coverage through a participating employer without evidence of insurability.

Evidence of insurability is required if the requested coverage is greater than $20,000 or the spouse is not added within 31 days of initial eligibility, which is the:

- Date of hire, if spouse is not an eligible employee;
- Date of marriage; or
- Date spouse is no longer eligible as an active employee.

Note: A spouse, who is a retiree subscriber, may be covered on Dependent Life-Spouse as a spouse within 31 days of the date he retires or during a specified enrollment period.

Follow the same procedures as outlined under Optional Life on Pages 50-53 for submitting medical evidence.

The Actively at Work requirement and the Dependent Non-confinement Provision, as explained in the IBG, apply.

Children: special eligibility requirements and changes in status

The subscriber is required to submit documentation to enroll a child as a dependent. If he fails to submit the required documentation, the dependent will be removed from coverage.

Any documentation that is in a language other than English must be completely translated into English and should be certified with a letter of accuracy from the translator.

The eligibility of a child is subject to review by PEBA.

Eligible children may be added to coverage within 31 days of the special eligibility situation. Otherwise, a child may be added to coverage during open enrollment.

Special eligibility situations allowing a subscriber to enroll himself and his eligible child(ren) in health, dental and/or vision coverage include marriage, birth, adoption/placement for adoption, placement of a foster child, gaining of legal custody, other court order or loss of other coverage.

Two employees cannot cover the same child(ren) under the same benefit (health, dental, vision, Dependent Life).

Child younger than age 26

A child who is younger than age 26 is eligible if either:

- The child is the employee's natural or adopted child, stepchild, foster child or child for whom the employee has legal custody; or
- The employee is required to provide health insurance because of a court order.

The subscriber must submit proof of the child's relationship to the subscriber within 31 days of enrollment and at other reasonable times.

Birth

Use the *Adding a dependent due to birth* checklist at peba.sc.gov/publications under *Life event checklists*.

A newborn may be added to coverage within 31 days of the date of birth.

The eligible employee may enroll himself, an eligible spouse, existing eligible dependents and the newborn in health, dental and/or vision coverage within 31 days of the date of birth.

- If the employee is already enrolled in health, he may change plans if he is adding his spouse or newborn to health.

The effective date of coverage is the date of birth of the newborn for health, dental and vision coverage.

Newborns are covered under Dependent Life-Child automatically for 31 days from live birth. A request must be submitted to continue Dependent Life-Child coverage beyond 31 days.

The eligible employee may add Dependent Life-Child, Dependent Life-Spouse ($10,000 or $20,000 without evidence of insurability) and Optional Life (up to $50,000 without evidence of insurability) within 31 days of the date of birth.

Dependent Life-Child coverage continues the first of the month after the date of the request.

Optional Life and Dependent Life-Spouse coverage begin on the first of the month following the date of the request if the employee is actively at work.

- If not actively at work, the effective date is the first of the month following the return to work.

The employee may be able to make changes to his Medical Spending Account or Dependent Care Spending Account.

The eligible employee must be on the plans or added with the spouse and/or newborn.

If the 31-day window to add the newborn is missed, the subscriber has 90 days (from the date on the rejection letter if the NOE is submitted after 31 days, or 90 days after the initial 31-day window) to send a written explanation and request for reconsideration to PEBA.

If the subscriber misses the 31-day window and 90-day appeal period explained above, coverage may be provided only from the date of birth through the end of the month after the first 31 days. To process claims for these 31 days of coverage, PEBA will need an NOE to add the infant for claims payment for the first 31 days and another NOE to drop coverage, effective the first of the month after the 31-day period. The request/NOEs to add and then drop may be submitted retroactively, up to 12 months.

Documentation

A long-form birth certificate showing the subscriber as the parent is the preferred document to add the newborn. However, if the child needs immediate service before the birth certificate can be obtained and the provider will not render services without proof of insurance, PEBA will accept an official document from the hospital signed by the attending physician or other hospital staff. The document must include the child's name, date of birth and parents' names.

A marriage license or Page 1 of the employee's latest federal tax return if filing jointly is required to add a spouse.

Note about premiums

If the employee is enrolled in the MoneyPlus Pretax Group Insurance Premium feature, premiums may be paid pretax beginning the first of the month following the date of the request.

Adoption/placement for adoption (child younger than age 18)

Use the *Adding a dependent due to adoption* checklist at peba.sc.gov/publications under *Life event checklists*.

A child younger than 18 may be added to coverage within 31 days of the date of the adoption/date of placement for adoption.

The eligible employee may enroll himself, an eligible spouse, existing eligible dependents and the newly

adopted child in health, dental and/or vision coverage within 31 days of the date of the adoption/date of placement for adoption.

- If the employee is already enrolled in health, he may change plans if he is adding his spouse or newly adopted child to health.

The effective date of coverage is the date of birth for health, dental and vision coverage if the baby is adopted or placed for adoption within 31 days of birth. If adopted or placed for adoption after 31 days of birth, the effective date is the date of adoption or placement for adoption.

The eligible employee may add Dependent Life-Child, Dependent Life-Spouse ($10,000 or $20,000 without evidence of insurability) and Optional Life (up to $50,000 without evidence of insurability).

Dependent Life-Child coverage is effective the date of birth if the baby is adopted or placed for adoption within 31 days of birth. If adopted or placed for adoption after 31 days of birth, the effective date is the date of adoption or placement for adoption.

Optional Life and Dependent Life-Spouse coverage begins on the first of the month following the date of the request if the employee is actively at work.

- If not actively at work, the effective date is the first of the month following the return to work.

The eligible employee may be able to make changes to his Medical Spending Account or Dependent Care Spending Account.

Exception: International adoptions. The effective date of coverage must be either:

- The date of adoption on the adoption paperwork (required documentation); or
- The date the child entered the U.S. A copy of the visa/visa stamp is required if using this date as the effective date of coverage.

If the adopted child is a newborn, please see Birth section on Page 104 for additional requirements if the 31-day window to add the child is missed.

The eligible employee must be on the plan or added with the spouse and/or newly adopted child.

Documentation
Acceptable documentation to add the newly adopted child includes a long-form birth certificate showing the subscriber as the parent; a copy of legal adoption documentation from a court, verifying the completed adoption; or a letter of placement from an adoption agency, an attorney or the Department of Social Services (DSS), verifying the adoption is in progress.

A marriage license or Page 1 of the employee's latest federal tax return if filing jointly is required to add a spouse.

Note about premiums
If the employee is enrolled in the MoneyPlus Pretax Group Insurance Premium feature, may be paid pretax beginning the first of the month following the date of the request.

Custody or guardianship

A subscriber who gains custody or guardianship over a child may add the child within 31 days.

The eligible employee may enroll himself only or any eligible spouse and/or child with new legal custody in health, dental and/or vision coverage.

- If the employee is already enrolled in health, he may change plans if he is adding his spouse or child with new legal custody to health.

The eligible employee may add Dependent Life-Child for eligible children (a foster child is not eligible for Dependent Life coverage).

The effective date of coverage is the date of custody or guardianship for health, dental, vision and Dependent Life-Child coverage.

The eligible employee may be able to make changes to his Medical Spending Account or Dependent Care Spending Account.

The eligible employee must be on the plan or added with the spouse and/or newborn.

Documentation
Acceptable documentation to cover a child with new legal custody includes a court order or other legal documentation from a placement agency or the S.C. Department of Social Services, granting custody or guardianship of a child/foster child to the subscriber. The documentation must verify the subscriber has guardianship responsibility for the child and not merely financial responsibility.

A marriage license or Page 1 of the employee's latest federal tax return if filing jointly is required to add a spouse.

Note about premiums
If the employee is enrolled in the MoneyPlus Pretax Group Insurance Premium feature, premiums must be paid post-tax for retroactive coverage back to the date of gaining custody or guardianship. Premiums may be paid pretax beginning the first of the month following the date of the request.

Divorce decree or court order

A child may be added to coverage. The child should be added to coverage within 31 days of the decree/court order.

The effective date of coverage is the first of the month after the court orders' date stamp from the Clerk of Court.

If the subscriber fails to drop the separated spouse within 31 days of the date on the order, the subscriber must wait until open enrollment or until another special eligibility situation occurs to add the child(ren).

Former stepchildren are not eligible and may not be covered, even if it is specified in the court order.

Special eligibility rules do not apply to National Medical Support Notices (NMSNs). See Page 43 for more information about NMSNs.

Documentation
A copy of the entire divorce decree or court order is required.

- The document should list what insurance the subscriber is directed to provide (i.e., health, dental, vision).).
- The document must list the name(s) of those to be covered.

Only the insurance listed may be provided for the child(ren) listed in the document.

Note about premiums
If the employee is enrolled in the MoneyPlus Pretax Group Insurance Premium feature, premiums must be paid post-tax for retroactive coverage back to the date of gaining custody or guardianship. Premiums may be paid pretax beginning the first of the month following the date of the request.

Child of foreign national employee

Add to coverage
A child of an eligible foreign national employee may be added to health, dental, vision and Dependent Life coverage within 31 days of arrival in the U.S.

A copy of the visa/visa stamp, showing the arrival date, and a copy of the long-form birth certificate showing the subscriber as the parent are required to add the child as a dependent.

A copy of the visa/visa stamp, showing the arrival date, a copy of the long-form birth certificate showing the name of the natural parent and proof that the natural parent and subscriber are married are required to add a stepchild as a dependent.

The effective date of coverage is the first of the month after arrival in the U.S.

Drop from coverage
A child of an eligible foreign national employee may be dropped from coverage within 31 days of departure from the U.S.

A copy of the visa/visa stamp, showing the departure date, is required to drop the child.

The effective date of coverage is the first of the month after departure from the U.S.

Child gains employment with coverage

A child who becomes eligible for other employer-sponsored group health coverage as an employee or as a spouse may continue his dependent coverage through the subscriber.

- If the child chooses to be covered under his parent's insurance as a dependent child, he is eligible only for benefits offered to children. The child is not eligible for Basic Life, Optional Life, Dependent Life-Child or Long Term Disability insurance.
- The child cannot be covered as a child on one insurance program, such as health, and then enroll for coverage as an employee on another, such as vision.
- The child should complete an *Active NOE* with his employer, refusing coverage. Under Type of Change on the NOE, next to Other, specify *Enrolled as child of PEBA subscriber*.
- If the child loses his coverage through his employer, and the child is otherwise eligible for coverage through the subscriber, the child may be re-enrolled within 31 days of the loss of coverage event or during open enrollment.
- If the child later decides to enroll in coverage as an employee, rather than as a dependent, he must complete an *Active NOE*.

The subscriber may drop the child within 31 days of when the child becomes eligible for other employer-sponsored group health coverage. The effective date is the first of the month after gaining coverage.

Note about premiums

If the employee is enrolled in the MoneyPlus Pretax Group Insurance Premium feature, premiums must be paid post-tax for retroactive coverage back to the date of gaining custody or guardianship. Premiums may be paid pretax beginning the first of the month following the date of the request.

Death of covered child

Use the *Death of a covered dependent* checklist at peba.sc.gov/publications under *Life event checklists*.

Upon the death of a covered child, the child must be dropped from coverage within 31 days of the date of death.

The effective date is the day after the child's date of death.

- Exception: If the subscriber fails to drop the child within 31 days of the death and this is the last eligible child, the request to change the level of health, dental, vision and Dependent Life, if applicable, may be changed retroactively, up to 12 months.

Note about premiums

If the employee is enrolled in the MoneyPlus Pretax Group Insurance Premium feature, premiums must be paid post-tax for retroactive coverage back to the date of gaining custody or guardianship. Premiums may be paid pretax beginning the first of the month following the date of the request.

Incapacitated child

An incapacitated, unmarried child who is incapable of self-sustaining employment because of mental illness or intellectual or physical disability and who is principally dependent (more than 50 percent) on the covered employee, retiree, survivor or COBRA subscriber for maintenance and support is eligible if:

- The child is covered at the time of incapacitation and has been continuously covered by a health insurance plan from the time of incapacitation;
- The child remains unmarried; and
- The incapacitation is established no earlier than 90 days before the child's 26th birthday but no later than 31 days after his 26th birthday.
- For the child to be covered under Dependent Life-Child, the incapacitation is established no earlier than 90 days before the child's 19th birthday but no later than 31

days after his 19th birthday or within 31 days of loss of student status.

PEBA determines whether the child is eligible to be considered for incapacitated child status.

Coverage for an incapacitated child may continue beyond age 26, when coverage would otherwise end, as long as the child remains eligible (this does not apply to children covered under COBRA). PEBA reserves the right to require the subscriber to submit satisfactory proof of such incapacity and dependency at any time. This proof is typically required within 31 days of initial enrollment, upon attaining age 26, and at other reasonable times, but not more frequently than annually.

A child who becomes incapacitated after age 26 is not eligible.

Incapacitated child certification procedures

If a covered child will turn age 26 within 90 days or the child is ages 19-25 and covered under Dependent Life-Child and incapable of attending school full-time, *and* if the child is incapacitated due to a mental or physical disability, the subscriber should complete an *Incapacitated Child Certification* form and send it to PEBA for a determination of eligibility.

If establishing incapacitation at age 26, this form should be sent to PEBA no earlier than 90 days before the child's 26th birthday and no later than 31 days afterward.

If establishing incapacitation within 31 days of loss of student status for Dependent Life-Child coverage, the subscriber must submit a completed *Incapacitated Child Certification* form and attach:

- A copy of the letter of withdrawal from the educational institution, verifying full-time student status up to the date of incapacitation; and
- A copy of the latest tax return, verifying the child is principally dependent on the subscriber. Tax schedules do not need to be included, and the tax return may be redacted as necessary.

Completing the *Incapacitated Child Certification* form

The subscriber must complete and sign Section A and the shaded areas of Section B.

If the child is ages 19-25, attach a copy of the letter of withdrawal from the educational institution, verifying full-time student status up to the date of incapacitation.

The dependent's physician must complete the remainder of Section B and sign Page 4.

The subscriber should also complete and attach an *Authorized Representative Form*, signed by the incapacitated child, to confirm permission for PEBA to discuss or disclose the child's protected health information to the particular person who acts as the child's Authorized Representative.

- If the child is incapable of signing the Authorized Representative Form, PEBA may accept, instead, documentation verifying the representative's authority to act on behalf of the child in these matters (i.e., guardianship papers or a power of attorney).

The subscriber returns the completed forms to PEBA for review, approval/denial and processing.

PEBA will forward the completed forms to The Standard for a review of the medical information provided, as well as the terms of the plan of benefits, and a recommendation. The Standard may request additional information from the subscriber and/or the child's health care providers. The Standard will forward its recommendation to PEBA, which makes the final determination based on the recommendation and documentation provided.

PEBA will notify the employer and the subscriber of its decision. Under HIPAA, no personal health information is disclosed to the benefits administrator.

If eligibility as an incapacitated child is denied, the subscriber has 31 days to submit additional medical

records and documentation to The Standard for review and reconsideration.

If the child's eligibility as incapacitated is denied, the subscriber can appeal the decision by writing to PEBA within 90 days of receipt of the denial letter. If the denial is upheld by PEBA, the subscriber has 30 days from receipt of the denial letter from PEBA to seek judicial review as provided by S.C. Code Ann. 1-11-710 and 1-23-380. For more information regarding the appeals process, please see Page 133.

The subscriber may be required periodically to recertify the child's incapacitation.

Child in full-time military service

A child in full-time military service is not eligible for Dependent Life-Child coverage.

Child turns age 26

Unless the child is approved to continue coverage as an incapacitated child, the child must be dropped from the subscriber's coverage when he turns 26.

The effective date is the first of the month after the child's 26th birthday.

Important note: The child will be dropped from coverage automatically, and any ineligible claims will not be paid.

Dependent Life-Child coverage

Eligible children may be added or dropped throughout the year, effective the first of the month after the request or effective the date of the event, if added within 31 days of birth, adoption, etc. No evidence of insurability is required.

If both parents are eligible for PEBA insurance benefits, only one can carry Dependent Life coverage for eligible children.

The Dependent Non-confinement Provision applies.

The subscriber pays one Dependent Life-Child premium to insure all covered children, and the subscriber is the beneficiary. There are no accidental death or dismemberment benefits for Dependent Life-Child.

Newborns are covered under Dependent Life-Child automatically for 31 days from live birth. A request must be submitted to continue Dependent Life-Child coverage beyond 31 days.

To be eligible for coverage, the child must be:

- Unmarried;
- Supported by the subscriber (however, a foster child is not eligible for Dependent Life coverage); and
- Younger than 19 years old; or at least 19 years old but younger than 25 and a full-time student, not employed on a full-time basis; or any age while certified as incapacitated.

Full-time students

A child who is at least 19 years old but younger than 25 and enrolled in and attending school in a full-time student status may be eligible for Dependent Life coverage as a full-time student.

- School includes high school, college or university (including graduate school), accredited technical, vocational or trade school or academic military academy.
- Full-time student status is defined by the institution.
- The student must be working toward a diploma or degree. Internet classes do qualify, provided they are offered through a school as defined earlier.

The child may be added to Dependent Life-Child coverage within 31 days of when he becomes a full-time student. The effective date is the first of the month after attaining full-time student status.

For students already covered, 90 days before a covered child's 19th birthday PEBA provides a letter in EBS for the benefits administrator to provide to the subscriber. The child's coverage will continue unless the subscriber notifies you that the child is no longer a full-time student or incapacitated child.

No Dependent Life claims will be paid for children who are at least 19 years old but younger than 25 who were not eligible as full-time students.

Dependent Non-confinement Provision

If a dependent is hospitalized or confined because of illness or disease on the date his insurance would otherwise become effective, his effective date shall be delayed until he is released from such hospitalization or confinement. This does not apply to a newborn child. However, in no event will insurance on a dependent be effective before the subscriber's insurance is effective.

Eligibility for MoneyPlus spending accounts

A list of who qualifies for reimbursement from a Dependent Care or Medical Spending account is in the *MoneyPlus Tax-favored Account Guide*. For more information, consult with a tax advisor.

COBRA notification by subscriber required

COBRA notification by the employee, spouse or other family member is required within 60 days for spouses and children when eligibility for health, dental and/or vision coverage ends.

Upon notification, issue the appropriate second notice to the employee, spouse or other family member. See the COBRA section for additional details.

Adoption Assistance Program

When funds are available and authorized in the state's budget, it is the policy of the State of South Carolina to provide financial assistance to eligible employees who are adoptive parents of a child, including a special needs child. This program is administered through PEBA.

Qualified applicants will receive:

- Actual adoption expenses, not to exceed $5,000 for a non-special needs child or $10,000 for a special needs child.
- When there are not enough funds available or authorized to meet every qualified applicant's expenses, funds will be divided evenly among the applicants. Those who adopted a special needs child will receive twice the amount as those who adopted a non-special needs child.

To be eligible, the adopting employee must be covered by PEBA insurance and must be employed when the adoption is finalized, when the application is submitted and when the payment is made.

As it relates to the Adoption Assistance Program, a **child** means any person younger than age 18. A stepchild is not eligible for adoption assistance benefits.

As it relates to the Adoption Assistance Program, a **special needs child**, means a child, as defined above, who meets other specific requirements set forth in the S.C. Code of Laws. For information on these requirements, contact Traci Rish with PEBA's Insurance Finance department at trish@peba.sc.gov or 803.734.1628.

Adoption assistance is not available for the adoption of a stepchild or for any other adoption involving a state employee who resides in the same home as the adopted child and the adopted child's parent.

Applications must be submitted between July 1 and September 30 for adoptions finalized the previous fiscal year (July 1-June 30). Following the September 30 deadline, payments will be sent to employees by the end of the following November. Payments cannot be sent to service providers.

Payments will be made to employees for costs related directly to the adoption, such as:

- Medical costs of the biological mother not covered by other insurance, Medicaid or other available resources;

- Medical costs of the child not otherwise covered;
- Licensed adoption agency fees, legal fees and guardian ad litem fees; and
- Allowable travel fees associated with the adoption process.

Adoption assistance is subject to taxes

Financial assistance through the Adoption Assistance Program is subject to federal income and FICA payroll taxes but is not subject to state income taxes. PEBA will withhold Social Security and Medicare payroll taxes (7.65 percent) from the benefit payment. *These withholdings will be forwarded to the employer.*

- The employer is responsible for the employer payroll tax match. This amount must be reported at the end of the year on the individual's W-2 in Box 3 (Social Security wages), Box 5 (Medicare wages) and Box 12 (using Code T — Miscellaneous Income).
- The employee is responsible for determination and payment of any federal income tax liability.

According to IRS Publication 15-B, *Employers Tax Guide to Fringe Benefits*, an employer must report all qualifying adoption expenses reimbursed to an employee under an adoption assistance program for each employee. IRS Publication 15-B is available online at www.irs.gov.

Comptroller General (CG) Agencies

If your employer is a CG agency, you are not responsible for reporting FICA taxes for adoption benefits. SCEIS will transfer the employer's FICA match from the STARS account. SCEIS will then forward the employee and employer FICA taxes to the IRS and report the adoption benefit and withholdings on the employee's W-2. A check for the net reimbursement from the Adoption Assistance Program will be issued to the employee, along with a letter explaining the deduction.

For more information or for an application, employees may contact PEBA.

Disability subscribers

Disability subscribers

View the Retirement, Disability and Death (RDD) employer insurance training materials at peba.sc.gov/insurance-training.

Workplace Possibilities

The odds of an employee returning to work after a disability diminish with time. The best chance for an employee to return to work is to do so as soon as possible. The Standard's Workplace Possibilities program may be able to help your disabled employee remain productive. The Workplace Possibilities program is an additional benefit that provides a disability consultant based in South Carolina who can help covered employees overcome barriers to job performance caused by their medical condition. The services are included in PEBA's disability policy.

Benefits Administrators may refer an employee for Stay at Work services while the employee is still working. The goal is to help the employee perform their job tasks. Return to Work services are provided soon after an employee goes out of work. The goal is to quickly return the employee to work.

Learn more about the program online and sign up for The Standard's blog at www.workplacepossibilities.com/blog.

How can I request services from the Workplace Possibilities team?

The first step is for the employee's manager to discuss the issue with the employee. Then, the benefits administrator should submit a *Stay at Work Request for Services* form and give the employee a one-page *Stay at Work Medical Information Request* form for their doctor to fill out and send to The Standard. The employee will also need to complete an *Authorization to Obtain and Release Health Information*. Once The Standard receives this information, a Workplace Possibilities consultant will contact your employee.

Eligibility

An employee may be eligible for retiree group insurance if he is approved for disability retirement benefits through one of the defined benefit plans administered by PEBA.

Disability retirement eligibility for South Carolina Retirement System members is based on entitlement to Social Security benefits. Police Officers Retirement System disability retirement claims are evaluated by a disability determination provider and a medical board.

State Optional Retirement Program (State ORP) does not provide disability protection. However, a State ORP participant may meet the retirement eligibility requirement for retiree group insurance through approval through The Standard for Basic Long Term Disability and/or Supplemental Long Term Disability. The State ORP participant must also be approved for disability by the Social Security Administration to be eligible for insurance as a disability retiree.

State ORP participants and employees of optional employers who do not participate in a PEBA administered retirement plan may meet the disability retirement eligibility requirements for retiree group insurance through disability approval by the Social Security Administration.

For more information about disability retirement, see Chapter 7 of the PEBA retirement benefits *Covered Employer Procedures Manual*. For more information about retiree disability insurance, see the Disability Retirement section in the Retirement and Disability chapter of the IBG.

Applying for disability benefits

An employee should apply for disability benefits as soon as he becomes disabled and **before leaving covered employment**. He or she may be eligible for optional life insurance benefits through MetLife and long-term disability through The Standard.

1. Complete and submit an *Application for Disability Retirement* to PEBA, if applicable.
2. Complete and submit optional life insurance information to MetLife, if applicable.
3. Complete and submit long-term disability information to The Standard, if applicable.

If the employee is unable to file, you may file on his behalf. The process may always be canceled, if the employee recovers.

Assisting a disabled employee

Use the *Disability retirement* checklist at peba.sc.gov/publications under *Life event checklists*.

If an employee is leaving employment due to disability:

- Follow the procedures for Terminations in the Transfers and terminations chapter.
- COBRA notification rules apply.
- If eligible for disability retirement, refer the employee to PEBA for assistance with filing for disability retirement.

If the employee applied for disability retirement with PEBA before he left covered employment, and he is terminated from employment before he receives approval, he may continue coverage through COBRA.

- He has 31 days from the date he leaves employment to apply for conversion of his life insurance with MetLife.
- If he is later approved for disability retirement, he may apply for retiree insurance within 31 days of the date of notification from PEBA. If he does not apply within 31 days of the date of notification, he must wait for a special eligibility situation or open enrollment to enroll as a retiree.

If the employee is covered as an active employee until he receives disability approval, he may apply for retiree insurance within 31 days of the date of notification from PEBA.

- If eligible, retiree coverage will be effective the first of the month following his termination from active coverage, provided he is terminated from active coverage on or after the date of retirement.
- If he does not apply within 31 days of the date of notification, he must wait for a special eligibility situation or open enrollment to enroll as a retiree.
- He has 31 days from the date of notification from PEBA to apply for continuation/conversion of his life insurance with MetLife.

Employees who are approved for BLTD/SLTD benefits cannot use that approval to apply for retiree insurance.

The effective date for insurance will be the first of the month following the date on the approval letter from PEBA (disability retirement), or from The Standard (BLTD/SLTD) as explained in the above bullet. The retiree must apply for coverage within 31 days of the date of the approval letter.

Review the deductible income/offset rules and overpayment potential for BLTD and SLTD benefits as explained in the Long Term disability chapter of the IBG.

If the employee becomes eligible for Medicare as a disability retiree through Social Security, advise the disabled employee he will need to enroll in Medicare Parts A and B. He must also notify PEBA within 31 days of eligibility and provide a copy of his Medicare card. He will no longer be able to contribute to an HSA if he enrolls in Medicare.

If the individual has end-stage renal disease, please read Page 88 in the Retiree Subscribers section for additional information about Medicare's coordination period.

If the employee does not qualify for retiree insurance, but enrolls in COBRA, he must notify PEBA when he is approved for Social Security disability benefits so PEBA can determine his eligibility for the 11-month extension of COBRA

coverage. Refer to the COBRA chapter for further instructions.

Optional Life

If the employee takes a leave of absence due to a total disability (as determined by the employer), his Optional Life (OL) coverage continues for up to 12 months by paying the premiums, beginning the first of the month after the last day worked.

- If he retires while on a leave of absence, he can choose to continue or convert his coverage within 31 days of leaving active employment, as explained below.
- If he dies while on a leave of absence, submit the claim to MetLife. Refer to the Claims and appeals chapter for further instructions.

If the employee does not return to work at the end of 12 months, terminate his coverage. He may be able to continue or convert his coverage within 31 days of his termination. Read Continuation/conversion below for more information and instructions.

- The employee can be considered eligible for Dependent Life coverage on his spouse's coverage, if applicable, when his eligibility for OL as an employee ends or if he converts coverage. He is not eligible if he chooses to continue his coverage.

Continuation/conversion

If the employee is approved for PEBA disability retirement and/or BLTD/SLTD, but does *not* qualify for retiree insurance benefits, he may continue or convert his OL coverage.

- He may also choose to split this coverage and continue a portion as a term policy and convert a portion to an individual policy.

If the employee is not approved for PEBA disability retirement or BLTD/SLTD, he can only convert his OL coverage.

The procedures for continuing and converting Optional Life coverage are explained on Pages 89-90.

Accelerated benefits

The accelerated benefits option may be available to active employees on a leave of absence who are terminally ill with a life expectancy of no more than 12 months. Claiming this benefit, which is 80 percent of his OL coverage, will reduce the amount of any optional life coverage and will reduce any optional life coverage eligible for continuation or conversion.

Complete a MetLife Accelerated Benefit Option claim. Refer to the Claims and appeals chapter for further instructions.

Basic Long Term Disability and Supplemental Long Term Disability

Eligibility for benefits

Eligibility for BLTD and SLTD benefits is based upon criteria using terminology from The Standard:

- Own occupation is a person who is unable to perform his own occupation as it is performed in the national economy during the benefit waiting period and the first 24 months for which LTD benefits are paid.
- Any occupation is a person who is unable to perform any occupation from the end of the own occupation period to the end of the maximum benefit period.
- Partial disability.

See the BLTD and SLTD plan certificates at peba.sc.gov/publications for details.

Note regarding partial disability

An employee may work in another occupation while he meets his own occupation's definition of disability. If the employee is disabled from his own occupation, there is no limit on his earnings in another occupation. However, the employee's earnings may be deductible income — BLTD/SLTD benefits may be reduced by this income.

BLTD/SLTD claim information

Refer to the Claims and appeals chapter for the procedures for filing claims and appeals. Below is some general information regarding claim documentation.

Satisfactory written proof that the employee is disabled and entitled to BLTD and/or SLTD benefits must be provided. Complete and submit the Long Term Disability Benefits Claim Form packet.

Time limits for filing and substantiating claims
An employee should submit a completed packet to The Standard as soon as possible, but within 90 days after the end of the benefit waiting period. The Standard will review the *completed claim* upon receipt.

In situations in which the employee is unable to obtain the information to submit a completed claim to The Standard within the time frame above, The Standard will accept completed claims up to one year after the 90-day period following the waiting period (see above).

If a completed claim is not filed within one year after the 90-day period following the waiting period, the employee's claim will be denied.

These time limits do not apply while the employee lacks legal capacity. In this situation, contact The Standard for additional information and instructions.

Documentation
If The Standard asks the employee to provide documentation to complete a claim packet, the employee must provide that documentation within 45 days of The Standard's request. Otherwise, the claim will be denied. The cost for providing the requested documentation is the employee's responsibility.

If The Standard asks a provider to provide documentation to complete a claim packet, the provider must provide that documentation within 45 days of The Standard's request. Otherwise, the claim may be denied.

BLTD/SLTD payments

The Standard may pay BLTD and/or SLTD benefits within 60 days after The Standard receives satisfactory proof of loss.

BLTD and/or SLTD benefits will be paid to an employee at the end of each month he qualifies for benefits. The payment should be received by the first of the month for the previous month.

Any BLTD benefits remaining unpaid will be paid to the employee's estate.

Any SLTD benefits remaining unpaid will be paid to the person(s) eligible to receive the survivor benefit that is defined in the SLTD policy. In case there are no eligible survivors as defined in the SLTD policy, survivor benefits are not paid, and any remaining SLTD benefits unpaid would be paid to the employee's estate.

No assignment
The rights and benefits of the SLTD and BLTD plans cannot be assigned (paid to a third party).

Advise of adjustments and potential overpayments
Remind any employee who is applying for BLTD and SLTD benefits that these benefits are reduced by other forms of deductible income, or offsets, as outlined in the IBG.

- These offsets are applied against BLTD and SLTD benefits, according to an individual's eligibility to receive them, regardless of whether he actually does receive them.

Eligibility for any benefits (Social Security, PEBA retirement benefits disability, workers' compensation, sick leave, return-to-work earnings, etc.) should be reported to The Standard immediately as they may be considered offsets.

Waiver of premiums

The SLTD premium waiver begins the first of the month after the end of the benefit waiting period, and premiums should continue until then.

The waiver ends when the employee returns to work. At that time, notify The Standard and complete the *SLTD Premium Waiver Form*.

The Standard prepays FICA and Medicare

BLTD and SLTD benefits are subject to taxes, including FICA and Medicare.

- The employee share of these taxes is deducted before the benefit payments are issued.
- Standard prepays the employer share and bills the employer quarterly for reimbursement of these amounts. You will receive a letter itemizing the charges. Follow the instructions outlined in the letter. If you receive such a letter and have any questions, please call Jeri Elsasser at The Standard at 971.321.5387.

When the benefits administrator should call The Standard

Notify The Standard when you become aware of any of the following events concerning an employee receiving SLTD and/or BLTD benefits:

- Employee receives deductible income/offsets (PEBA retirement benefits disability or retirement benefits, Social Security disability or retirement benefits, workers' compensation benefits, sick leave or shared leave, etc.);
- Employee returns to work in any capacity;
- Employee needs help or assistance in returning to work;
- Employee dies; or
- Employee is terminated.

MoneyPlus

If on leave due to disability, the employee can continue his MoneyPlus accounts as explained on Page 56 under Unpaid leave or reduction in hours.

If the employee is eligible for disability retirement through PEBA, his options are explained in the Retiree subscribers chapter of this manual.

Claims and appeals

Claims and appeals

Many of the claims and appeals procedures are outlined in the IBG. Refer to the appropriate benefit sections of the IBG for general claims and appeals information and procedures.

This section highlights specifics related to filing claims and appeals that are not included in the IBG and that you might need to know as a benefits administrator.

State Health Plan claims

Network providers file claims for subscribers. However, to receive benefits when a hospital or doctor does not file, subscribers can file a claim manually, as outlined in the IBG.

Tips for filing claims

The insured's name on *the State Health Plan Benefits Claim Form* should match the subscriber's name on file with PEBA.

Subscribers should allow about three weeks to receive an *Explanation of Benefits* (EOB) before calling BlueCross or PEBA for assistance.

Claims should be filed as soon as possible, but MUST be filed no later than the end of the calendar year following the year in which expenses are incurred. Claims filed after that time will be denied.

The claim form cannot be used to make an address change. Subscribers can update their addresses online using MyBenefits.

State Health Plan claims for services outside the U.S.

Claims outside the U.S. are filed for subscribers through the BlueCross BlueShield Global® Core provider network.. However, to receive benefits when a hospital or doctor does not file, subscribers can file the *BCBS Global Core International Claim Form* manually.

Coordination of benefits

State Health Plan benefits for health and prescription drug coverage are coordinated with other coverage that a subscriber, his covered spouse or his covered children may have. Refer to the IBG for the general rules about how to determine which plan is considered primary or secondary.

Prescription drug benefit

If the State Health Plan is the secondary payer for prescription drug benefits when coordination of benefits applies, the covered person should present the primary insurance card first.

The covered person would then file a manual claim using the *Prescription Drug Claim Form* for any benefits due as the secondary payer.

A person with a MoneyPlus debit card is advised not to use the card at the pharmacy when the State Health Plan is the secondary payer, because the manual claim must be filed to determine the amount of unreimbursed expense before filing a Medical Spending Account claim.

Claims for an active subscriber with Medicare

Medicare is the secondary payer under the active employer, unless the employee, spouse or child is enrolled in Medicare solely due to end-stage renal disease.

When an active employee, his spouse or his child(ren) is enrolled in Medicare, claims are filed with BlueCross first. Once the employee receives the *Explanation of Benefits* (EOB), he should send an itemized bill and a copy of the EOB to Medicare to be processed for secondary benefits.

If an employee is enrolled in Medicare solely due to end-stage renal disease, contact Medicare for additional information. After 30 months, Medicare becomes the primary payer for a subscriber with end-stage renal disease.

Claims for a retiree subscriber with Medicare

Medicare is the primary payer for a retiree who is eligible for Medicare. The State Health Plan (including the Medicare Supplemental Plan)

coordinates claims payment as though the subscriber is enrolled in Medicare Part A and B, regardless of whether the subscriber is actually enrolled. Prior to Medicare eligibility, the Plan is the primary payer.

A retiree, who is not eligible for Medicare by his own employment record, but who may become eligible on a spouse's employment record, must enroll for Medicare when the spouse enrolls. If either refuses Medicare coverage, the Plan still coordinates claims payment as if they have both Part A and Part B benefits. If the Medicare-eligible subscriber is not covered by Part A and Part B, he will be required to pay the portion of his health care costs that Part A and Part B would have covered.

Accident questionnaires

For accident-related claims, BlueCross may need information about the event. BlueCross gathers this information through an accident questionnaire. Gathering this information is typically related to subrogation, when more than one party is involved in the accident. Subrogation is explained under *Helpful terms* in the IBG.

Questionnaires are sent to subscribers when there is a claim filed for treatment of an injury or diagnosis that has been established by BlueCross' staff of physicians as likely to be an accident or work-related.

Questionnaires are generated once per week. Subscribers can receive multiple questionnaires related to the same event, due to any of the following:

- BlueCross may not have received a response to the first questionnaire before a second one is sent. Additional questionnaires will be sent to the subscriber each week until BlueCross receives a completed one.
- Subscribers may also receive more than one questionnaire if more than one covered person in the family receives treatment related to the same accident. A separate questionnaire is sent for each covered individual being treated for injuries related to the accident. The name of the patient is included at the top of the questionnaire.
- Once BlueCross receives a questionnaire response, it is valid for six months. If claims meeting the established accident-related criteria are reported more than six months after the original accident date, the subscriber will receive another questionnaire. This six-month cycle helps BlueCross identify any subsequent accidents that may have occurred.
    - If claims reported more than six months after the original accident are related to that event, the subscriber should simply check the update space and return the questionnaire to BlueCross. This will update the subscriber's file for another six months.

Other health/dental questionnaire

BlueCross sends this questionnaire to subscribers who cover dependents under the health and/or dental coverage to determine if the dependent has other primary coverage.

Dependent claims can be suspended until the questionnaire is returned to BCBS.

Upon receipt of the questionnaire, it is valid for one year.

Mental health and substance use claims

Office visit services for psychological or neuropsychological testing and applied behavior analysis and all hospital inpatient, partial and intensive outpatient program admissions must be preauthorized by Companion Benefit Alternatives (CBA).

In-network claims

The provider files claims when the subscriber, his covered spouse or his covered child(ren) use a

provider that participates in the mental health and substance use provider network.

Out-of-network claims

The subscriber must complete and submit a claim form for out-of-network services. The claim form is the same for State Health Plan medical claims and mental health and substance use claims. The subscriber can file a claim manually as outlined in the IBG.

Dental Plus and Basic Dental claims

Most dental offices can file claims directly with BlueCross. However, to receive benefits when a dentist does not file directly, subscribers can file a *Dental Claim Form* manually as outlined in the IBG.

Tips for filing claims

The subscriber's name on the dental claim form should match the subscriber's name on file with PEBA.

A Pretreatment Estimate from BlueCross must be returned with the claim after the services are rendered. These estimates are valid for one year.

Subscribers should allow about three weeks to receive an *Explanation of Benefits* (EOB) before calling BlueCross or PEBA for assistance.

Claims should be filed as soon as possible, but MUST be filed no later than 24 months following the date charges were incurred. Claims filed after that time will be denied.

The claim form cannot be used to make an address change. Subscribers can update their addresses online using MyBenefits.

State Vision Plan claims

In-network claims

There are no claims to file when the subscriber uses a provider that participates in EyeMed's provider network.

EyeMed no longer requires pre-authorization for medically necessary contact lenses. The provider is responsible for determining adherence to the criteria and submits a medically necessary contact lens claim form to EyeMed directly.

Out-of-network claims

The subscriber must complete and submit an *Out-of-Network Vision Services Claim Form* to be reimbursed for eligible expenses.

EyeMed will accept only itemized, paid receipts that list the services and the amount charged for each service. Handwritten receipts must be on the provider's letterhead.

Itemized receipts should be attached to the completed claim form and mailed to EyeMed's Out-of-Network Claims department at the address on the claim form's instructions page or follow instructions to submit claims online.

Claims must be submitted within 15 months of the date of service.

Denials and appeals

Because the Vision Plan is fully insured, subscribers cannot appeal EyeMed determinations to PEBA.

If a claims question cannot be resolved by EyeMed's Customer Care Center, the subscriber may write to:

EyeMed Vision Care
Attn: Quality Assurance Department
4000 Luxottica Place
Mason, OH 45040

Information may also be faxed to 513.492.3259. EyeMed will work with the subscriber to resolve the issue within 30 days. If the subscriber is dissatisfied with EyeMed's decision, the subscriber may appeal to an EyeMed appeals subcommittee. All appeals are resolved by EyeMed within 30 days of the date the subcommittee receives it.

Life insurance claims

Policy Number 200879

Submit the termination in EBS to cancel life insurance coverage and submit the life insurance claim with MetLife.

Submitting the claim

Log in to MetLink to submit a claim. Using the *Submit a Claim* function, select a *Claim Type* and indicate who the *Claim is for* from the drop-down lists. Complete the required information, including the employee, coverage and informant/beneficiary information. Review the information for accuracy, edit if necessary, and submit the claim.

Once submitted, you may upload supporting documentation for the claim. Required forms for a standard life claim include:

- Completed Claimant Statement;
- Original death certificate;
- Last two years of enrollment documentation;
- Most recent beneficiary designation documents; and
- Additional documentation such as accident and toxicology and/or autopsy reports, if applicable.

Share the life insurance claim kit, available in the *Life insurance claim* form, with the claimant(s). The kit includes the Claimant Statement.

Using a paper claim form

You may also complete and return a paper employer statement of the *Life insurance claim* form to MetLife. Please allow additional time for processing of paper forms.

1. If a subscriber dies, complete sections 1, 2 and 4 of the employer statement.
   - Employer name is South Carolina PEBA and group number is 200879 in Section 1.
   - In Section 4, indicate the type of benefit coverage, effective date(s) and list the benefit amount coverage.
   - Attach a copy of the subscriber's SOE, SOC or NOE showing his coverage amount.
   - Attach beneficiary designation and any additional beneficiary contact information.
2. If a dependent dies, complete sections 1, 3 and 4 of the employer statement. See above for more information.

Send the completed claim form, along with coverage beneficiary information, to MetLife.

- Fax to 570.558.8645; or
- Mail to
  MetLife
  Group Life Claims
  P.O. Box 6100
  Scranton, PA 18505-6100

Notification

After MetLife receives the completed claimant statement and certified death certificate, the claim will either be approved, and payment will be made to the beneficiary, or the claim will be denied, and MetLife will send a notification of denial to the beneficiary.

Claims that are completed and submitted properly are typically processed within 10 business days, unless there are extenuating circumstances surrounding the death.

Allow at least 10 business days before checking the claim status if it is an uncomplicated claim. More complicated claims — accidents and homicides — may require an in-depth investigation. MetLife may also need to request additional medical information. Payment will be determined after the investigation is complete. If a beneficiary has a question about the status of a life insurance claim, he may call MetLife at 800.638.6420, then press 2.

Retirees

If the claim is for a deceased retiree, the beneficiary should call MetLife at 888.507.3767. The necessary claim form will be sent to the correct party for completion. MetLife will need to verify that the retiree has continued the coverage into retirement.

Claims payments

MetLife will pay life insurance benefits to the beneficiary or beneficiaries as indicated on file with PEBA. *Exceptions* include:

- **Estate of the insured**: Benefits will be paid to the administrator or executor of the deceased's estate.
- **A minor**: Benefits will be paid to the court-appointed guardian for the minor and minor's estate.
- **An incompetent beneficiary**: Benefits will be paid to the guardian or other appointed representative for the beneficiary.

If applicable, a court certificate showing the appointment must be submitted. Do not delay submitting proof of death. Send it in, noting the court certificate of appointment is pending.

When the claim is approved, MetLife will send a payment notice to the beneficiary.

Claims for employees and dependents, regardless of how they were originally submitted, can be searched in MetLink.

Assignment

MetLife is not responsible for the validity or tax consequences of any payment to a third party (called *assignment*). An assignment is the irrevocable, legal transfer of some or all of the *interest* (amount payable in the future) under a policy to a third party. The individual with the interest (e.g., the insured) makes the irrevocable assignment. The insured can assign certain rights, such as, but not limited to:

- The right to convert group coverage to individual coverage;
- The right to designate or change a beneficiary;
- The right to accelerate death benefits, if applicable; and
- The right to increase coverage, as applicable.

No assignment will be binding on MetLife until MetLife receives a completed *Absolute Assignment to Trust* form, records and acknowledges it.

Assignments for collateral are not permitted (such as for a loan).

PEBA will maintain a copy of records of death claim payments.

Accidental death benefit

Completing and filing an *Accidental Death & Dismemberment Claim* form in cases of accidental death can be done using MetLink. Complete and submit the claim information, as instructed in MetLink.

See the Life Insurance chapter of the IBG for descriptions of additional accidental death benefits.

Suicide

Suicide is a covered life claim; however, double-indemnity benefits are not payable. No Optional Life or Dependent Life-Spouse benefits are payable if death results from suicide, whether sane or insane, within two years of the effective date.

If death occurs within two years of the effective date of an increase, the death benefit payable is limited to the amount of coverage prior to the increase.

Other benefits

Dismemberment benefits

If a claim is for dismemberment or loss of vision, the benefits administrator, employee and his physician must complete the *Accidental Death & Dismemberment Claim* form and submit it to MetLife. Dismemberment benefits are not available to retirees or dependent children.

Accelerated benefits option (Living benefit option)

When a physician diagnoses an employee or his covered dependent spouse as terminally ill with a life expectancy of no more than 12 months, the employee may request that MetLife pay up to 80

percent of his Optional Life or Dependent Life-Spouse benefit prior to death, up to $400,000. The benefits administrator, employee and his physician must complete the *Accelerated Benefit Option* form and submit it to MetLife. When the ABO is used, a death certificate must be submitted to MetLife to obtain the remaining benefit. There is no need to complete an additional claim form.

If terminating employment, refer to the Transfers and Terminations chapter for additional information and procedures.

Dependent Life

Policy Number 200879

Follow the claims procedures explained on Page 127.

File a claim using MetLink. If the spouse or child was the last eligible covered family member, and the level of coverage is affected by the spouse's or child's death, the employee has 31 days to complete the coverage change.

If coverage is not affected, to delete the spouse's or child's name the employee must still complete, sign and date an NOE.

Dependent Life pays double the amount for accidental death of a covered spouse, but not a covered child.

Dependent Life Accidental Death and Dismemberment

The procedures for filing accidental death and dismemberment claims for covered spouses are the same as for employees.

Denials and appeals (Optional Life and Dependent Life)

If a claim is denied, MetLife will notify the claimant in writing. The notice of denial states:

- The specific reason(s) for the denial;
- A reference to the plan provisions on which the denial is based; and
- An explanation of the review procedure.

The claimant may request an appeal in writing.

- Eligibility appeals should be sent to PEBA. For more information regarding the PEBA appeals process, please see Page 131.
- All other appeals should be sent to MetLife.

Long term disability claims

Basic Long Term Disability

(BLTD Policy #627284-B)

Supplemental Long Term Disability

(Policy #621144-B)

Provide employees with the latest LTD Certificate(s) of Coverage(s). Both certificates of coverage, for BLTD and SLTD, are available publications on the PEBA website.

The *LTD Benefits Claim Form packet* applies to both BLTD and SLTD claims. It should be completed as soon as the employee is absent from work for more than 31 days or when modified duties have exceeded 31 days. Employees may work part-time or have modified duties and still be eligible for benefits.

Detailed instructions are included on the first two pages of the packet. If the employee is not able to apply for benefits, you may apply on behalf of the employee.

Satisfactory written proof that the employee is disabled and entitled to BLTD and/or SLTD benefits must be provided. The claim form packet must be completed by the appropriate parties in its entirety.

Please note the following:

- The employee completes the *Employee's Statement* in its entirety.
- The employee signs and dates the *Authorization to Obtain and Release Information*.
- The employee also signs and dates the *Authorization to Obtain Psychotherapy Notes*, if applicable.

- The employee should forward the *Employee's Statement* and both *Authorizations* to The Standard at the address on the form.
- The employee completes only Part A of the *Attending Physician's Statement* and forwards it to his physician, who should complete Part B. The physician should forward the completed *Attending Physician's Statement* directly to The Standard at the address on the form.
- The employee should complete Section 1 of the *Employer's Statement* and forward it to his benefits administrator. You should then complete the *Statement* and forward directly to The Standard at the address on the form.

Time limits for filing and substantiating claims

An employee should submit a completed packet to The Standard as soon as possible, but within 90 days after the end of the benefit waiting period (90 or 180 days, based on the chosen benefit waiting period). The Standard will review the *completed claim* upon receipt.

In situations where the employee is unable to obtain the information to submit a completed claim to The Standard within the timeframe above, The Standard will accept completed claims up to one year after the 90-day period following the respective benefit waiting period.

If a completed claim is not filed within one year after the 90-day period following the waiting period, the employee's claim will be denied.

These time limits do not apply while the employee lacks legal capacity. In this situation, you should contact The Standard for additional information and instructions.

Documentation

If The Standard asks the employee to provide documentation to complete a claim packet, the employee must provide that documentation within 45 days of The Standard's request. Otherwise, the claim will be denied. The cost for providing the requested documentation is the employee's responsibility.

If The Standard asks a provider to provide documentation to complete a claim packet, the provider must provide that documentation within 45 days of The Standard's request. Otherwise, the claim may be denied.

Investigation of claim

Once The Standard receives a completed claim packet, The Standard will review the claim and gather any additional information necessary to make a determination on the claim.

The Standard continues to manage the employee's claim and may investigate the claim at any time for the duration of the claim.

At The Standard's expense, The Standard may have the employee examined at any time by specialists of The Standard's choice. The Standard may deny or suspend benefits if an employee fails to attend an examination or cooperate with the specialist.

If The Standard approves the employee for SLTD benefits, The Standard will notify PEBA, the employee and the benefits administrator of the approval.

- The employee's premiums are waived while SLTD benefits are payable.
- PEBA will process the waiver of premiums and generate a letter to the benefits administrator, requesting PEBA be notified immediately if the employee returns to work.

Denials and appeals

If the claim is denied, the decision is made within a reasonable period (in most cases, no more than 105 days) and communicated afterward. The notice of denial states:

- The specific reason(s) for the denial;
- A reference to the plan provisions on which the denial is based; and

- A description of additional information or material that may reverse the denial decision and why it is necessary.

How to request an appeal of a long term disability claim

The claimant can write to Standard Insurance Company, P.O. Box 2800, Portland, OR 97208, to request a review. The request must be made to The Standard within six months of receipt of the denial letter. The claimant should include any additional documentation to be considered.

The claimant will receive notification of The Standard's final decision within 90 days of the request, or within 120 days if special circumstances require an extension.

If The Standard reviews the claim and upholds the denial, the claimant will receive correspondence from the Administrative Review Unit at The Standard, including instructions for appealing the decision.

BLTD only: If The Standard upholds its decision on a claim

An appeal may be filed with PEBA within 90 days of the notice of denial.

If the denial is upheld by PEBA, the subscriber has 30 days from receipt of the denial letter from PEBA to seek judicial review as provided by S.C. Code Ann. § § 1-11-710 and 1-23-380.

Please note: Because Supplemental Long Term Disability is fully insured by The Standard, SLTD decisions may not be appealed to PEBA.

Refer to the Disability Subscribers section of this manual for additional information.

MoneyPlus claims and reimbursement

Medical Spending Account and Dependent Care Spending Account reimbursements

The employee files claims for reimbursement directly with ASIFlex.

ASIFlex offers several easy ways to submit claims for reimbursement. Employees can use any of these options throughout the year:

- ASIFlex website;
- ASIFlex mobile app; or
- MoneyPlus claim form.

If approved, reimbursement will be made within three business days of receipt. Reimbursement may be direct deposited into bank accounts within one day of processing a claim.

Employees can log in to their ASIFlex account to sign up for direct deposit, as well as email and text alerts. Employees can also opt to receive a mailed check.

There is no reimbursement minimum for direct deposit. The minimum check reimbursement is $25, except for the last reimbursement, which brings an account balance to zero.

Special notes on Medical Spending Account reimbursements

Only eligible expenses may be claimed. Any medical expenses that are already covered by health, dental or vision insurance are not reimbursable.

Medical Spending Account (MSA) reimbursements are issued for the full amount of the claim, regardless of the employee's account balance, up to the unused portion of the elected annual deduction.

If not continuing an MSA after termination through COBRA, the employee has through the run-out

period to submit claims incurred during his period of coverage while he was an employee.

ASIFlex debit card reimbursements
The ASIFlex debit card may be used at:

- Medical service providers, such as physician and dental offices, hospitals, medical labs;
- Prescription drug mail-order websites, such as Express Scripts Pharmacy, the State Health Plan's mail-order prescription drug service; and
- Pharmacies and any other stores that use Inventory Information Approval Systems (IIAS).
    - Prescriptions and eligible over-the-counter items are coded and identified electronically by the debit card and other MSA card programs. Only the items that are IIAS coded may be purchased with the card. *Example*: If you go to Walgreens, an IIAS-user, and buy a prescription, contact lens solution and a magazine, the charge for the magazine will not process. It must be paid for separately.

Persons with an ASIFlex debit card should not use the card at a pharmacy if they have other coverage, because claims for both primary and secondary plans must be filed to determine the amount of *unreimbursed* expense before filing a MSA reimbursement.

Documentation
ASIFlex will receive claims information from other third-party vendors to auto-adjudicate as many card transactions as possible. Use of the card, however, is not paperless. Employees may be required to submit documentation to substantiate claims.

Requests for documentation are emailed and posted to an online secure message center. A participant has 52 days to respond.

- An initial notice is sent approximately five days after ASIFlex receives notice of transaction.
- A reminder notice is sent 21 days after initial notice.
- A deactivation notice is sent 21 days after reminder notice.
- Future claim submissions are offset by any outstanding amount.

Card transactions that remain unsubstantiated by March 31 after the end of the plan year are taxable as income, and ASIFlex will send a report to employers listing all unsubstantiated card transactions. Refer to the Accounting, Billing and Reports section of this manual for additional information.

Special notes on Dependent Care Spending Account reimbursements

The dependent care provider may sign the MoneyPlus claim form where indicated in lieu of an itemized receipt.

There must be sufficient funds in the account balance to reimburse expenses. Payroll deductions from the employer are submitted to ASIFlex. If no payroll discrepancy, ASIFlex will post contributions to accounts within one business day of receipt or on the actual payroll date, whichever is later.

If an employee submits a reimbursement request before ASIFlex receives and posts the payroll deduction, the request is suspended and then paid within three business days after the payroll deduction posts.

A suspended request also results when an employee incurs expenses for more than the account balance. Payment for the balance is issued. Additional reimbursements are issued as the payroll deduction posts and the funds become available.

Health Savings Account reimbursements

There must be sufficient funds in the bank account balance to reimburse expenses. Payroll deductions

from the employer are submitted to ASIFlex. If no payroll discrepancy, ASIFlex will send contributions to Central Bank to post to participants' accounts within one business day of receipt or on the actual payroll date, whichever is later.

Employees who enroll in a Health Savings Account (HSA) must open a bank account with Central Bank, and provide a validation code from Central Bank in MyBenefits to complete the enrollment transaction.

The participant is responsible for reimbursing himself from his HSA by using his HSA debit card at the time of service or transferring funds from his HSA to his checking account online.

The participant is responsible for ensuring that he reimburses himself *only for eligible expenses*.

The participant is responsible for retaining documentation and providing it to the IRS, if requested.

See the *MoneyPlus Employer Payroll User Quick Guide* for more information about payroll deductions.

Administrative or eligibility appeals

If an employee, retiree, survivor, spouse, former spouse or child(ren) is unable to enroll, disenroll or change their coverage, the subscriber has the right to a review.

Examples include, but are not limited to:

- Eligibility for incapacitated child coverage;
- Enrollment in MoneyPlus;
- A coverage change request outside of an open enrollment period;
- A coverage change request more than 31 days after a special eligibility situation occurs;
- Eligibility for nonfunded, partially-funded or funded retiree coverage;
- Extension of COBRA coverage; and
- Removal of the tobacco and e-cigarette use premium.

Retirees, survivors and COBRA subscribers of state agencies, public school districts or public higher education institutions can submit requests directly to PEBA, which serves as their benefits administrator.

Retirees, survivors or COBRA subscribers of optional employers can submit requests through the benefits office of their former employer, which serves as their benefits administrator.

Employees may request a review through their benefits administrator.

Request for Review process

Submit a request for review (RFR) through EBS under Manage Subscribers. See the *Using the online enrollment system* section of this manual.

An RFR describes the active subscriber's issue, explains the surrounding circumstances and includes any supporting documentation. Upon the employee's request, you must submit the RFR regardless of whether you support the subscriber's request.

If a mistake was made by the benefits office, such as misplacing or failing to submit documentation in a timely manner, select the reason as *Late - Employer* or *Correction – Employer* from the drop-down list of reasons. Include a summary of the change requested, explain the circumstances of the request and upload any supporting documentation. Subscriber negligence is not considered an employer delay or correction.

If no mistake was made by your benefits office, select the reason as *Late - Employee* or *Correction – Employee* from the drop-down list of reasons. Include a summary of the change requested, explain the circumstances of the request and upload any supporting documentation.

If the RFR is approved, the transaction will apply with the requested effective date and the transaction will no longer appear on your RFR tab.

Any premiums due must be paid therefore it is imperative that the subscriber understand the possibility of retro premiums.

If the RFR is rejected, an explanation of what needs to be done to correct the error will be shown on the suspended transaction.

If it is denied, the status changes to *PEBA Denied* and the employee will receive an email. View the RFR Denial and denial reason and save or print prior to your acknowledgement. Remember to place a copy of the denial in the employee's file.

View the Request for Review (RFR) tutorial video at peba.sc.gov/insurance-training.

If completing a request on the paper *Request for Review* form, complete the form in its entirety and mark the change reason as either a *BA clerical error or delay* or a *Subscriber request*. Explain the circumstances of the request and attach any supporting documentation.

- If making a change to coverage, you need to include an original NOE, completed and signed by you and the subscriber. The NOE must correct the error addressed on the form.
- Attach an NOE whenever an effective date correction is more than 90 days retroactive.
- If denied, PEBA will send you a denial which must be sent to the subscriber, notifying him that he has 90 days to appeal to PEBA.

A request for review is not required for retroactive termination of a subscriber's file. If the retroactive termination exceeds 31 days, the employer is responsible for paying any premiums beyond the 31-day period, back to the date of termination.

If the request is approved due to an employer delay or error, the approval is effective retroactively, up to one year back to the actual effective date. Any premiums due must be paid. Changes cannot be made prospectively or for the date the request is made.

Example: A new employee was hired on March 1, 2019, but due to an employer delay, the enrollment is not submitted to PEBA until July 1, 2020. PEBA receives a request for review and enrollment to add the employee effective July 1, 2020.

- The employee will be added effective July 1, 2019 - one year retroactive from PEBA's receipt of the request, as the request was received more than one year after the hire date of March 1, 2019. Premiums are due from July 1, 2019, forward.

Appeal process

If the subscriber disagrees with PEBA's decision, the subscriber may appeal in writing to PEBA within 90 days of the denied request. The subscriber should explain why he is appealing, attach any additional information and supporting documents and include a copy of the denial.

If the request for review was denied because of lack of documentation, the subscriber should include the previously missing documentation.

A benefits administrator, employer or healthcare provider may not appeal to PEBA on the subscriber's behalf. Only the subscriber, his authorized representative or a licensed attorney admitted to practice in South Carolina may initiate an appeal through PEBA. A benefits administrator, employer or healthcare provider may not be an authorized representative.

In most cases, the appeal should be sent to IAD@peba.sc.gov or:

S.C. PEBA
Attn: Insurance Appeals Division
202 Arbor Lake Drive
Columbia, SC 29223

If the appeal is urgent and relates to a pregnancy, newborn child or the preauthorization of a life-saving treatment or drug, the subscriber may send the appeal to urgentappeals@peba.sc.gov.

PEBA will review the request and make every effort to process the subscriber's appeal within 180 days

of the date all of the appeal information is received. However, this time may be extended if additional material is requested or if the subscriber asks for an extension. PEBA will send the subscriber periodic updates on the status of the review. Once PEBA's review of the appeal is complete, the subscriber will receive a written determination in the mail.

If the appeal is approved, PEBA will process the enrollment and notify the subscriber and his benefits administrator of any other needed documentation.

If the appeal is denied, PEBA will send the subscriber a detailed decision letter explaining the reason(s) for denial. The subscriber will then have 30 days to seek judicial review at the Administrative Law Court, as provided by Section 1-11-710 and 1-23-380 of the S.C. Code of Laws, as amended.

Appeals related to claims or authorization of benefits

If an employee, retiree, survivor, spouse, former spouse or child is seeking authorization of benefits or reimbursement for a claim, the subscriber has the right to a review.

Vision, Life Insurance and Supplemental Long Term Disability benefits are fully insured products and are not to be appealed to PEBA. Page 133 describes the appeals process for these fully insured products.

All other coverage issues related to claims or the authorization of benefits are appealed first to the applicable third-party claims administrator and then to PEBA. Examples include, but are not limited to:

- Preauthorization of medical, behavioral health, or dental services, and treatments or devices;
- Prior authorization of prescription medication;
- Reimbursement of MoneyPlus claims;
- Reimbursement of claims for medical, behavioral health or dental services, and treatments, or devices; and
- Payment for Basic Long Term Disability claims.

If a subscriber request for authorization of benefits or reimbursement for a claim from the appropriate third-party claims administrator is denied, then the subscriber can appeal to the third-party claims administrator within:

- Three days for radiology preauthorization appeals;
- 31 days for MoneyPlus appeals; and
- Six months for other appeals.

If the third-party claims administrator denies the appeal, the subscriber can appeal to PEBA within 90 days.

Exception: The pharmacy benefits manager, Express Scripts, may conduct one to three reviews, depending on the circumstances of the appeal. Once the appeals process is completed, Express Scripts will send a decision letter to the subscriber. If denied, the denial letter will describe the subscriber's appeal rights to PEBA. The subscriber will still have 90 days to appeal to PEBA.

Third-party claims administrators

- **BlueCross BlueShield of South Carolina** (health insurance claims)
  StateSC.SouthCarolinaBlues.com
  803.736.1576 or 800.868.2520
- **Medi-Call** (medical preauthorization)
  803.699.3337 or 800.925.9724
- **Companion Benefit Alternatives** (behavioral health benefits preauthorization)
  www.CompanionBenefitAlternatives.com
  803.736.1576 or 800.868.2520
- **National Imaging Associates** (radiology preauthorization)
  www.RadMD.com
  866.500.7664
- **Express Scripts** (prescription medication)
  Attn: Benefit Coverage Review Department
  P.O. Box 66587
  St. Louis, MO 63166-6587

- **BlueCross BlueShield of South Carolina** (dental claims)
  Attn: State Dental Appeals
  AX-B15
  P.O. Box 100300
  Columbia, SC 29202-3300
- **Standard Insurance Company** (Basic Long Term Disability)
  P.O. Box 2800
  Portland, OR 97208
- **ASIFlex** (MoneyPlus claims)
  ASIFlex Appeals
  Attn: S.C. MoneyPlus
  P.O. Box 6044
  Columbia, MO 65205-6044

Once the subscriber has received the denial letter from the third-party claims administrator with the 90-day appeal language, the subscriber can appeal to PEBA.

A benefits administrator, employer or healthcare provider may not appeal to PEBA on the subscriber's behalf. Only the subscriber, his authorized representative or a licensed attorney admitted to practice in South Carolina may initiate an appeal through PEBA. A benefits administrator, employer or healthcare provider may not be an authorized representative.

In most cases, the appeal should be sent to IAD@peba.sc.gov or:

S.C. PEBA
Attn: Insurance Appeals Division
202 Arbor Lake Drive
Columbia, SC 29223

If the appeal is urgent and relates to a pregnancy, newborn child or the preauthorization of a life-saving treatment or drug, the subscriber may send the appeal to urgentappeals@peba.sc.gov.

PEBA will review the request and make every effort to process the subscriber's appeal within 180 days of the date all the appeal information is received. However, this time may be extended if additional material is requested or if the subscriber asks for an extension. PEBA will send the subscriber periodic updates on the status of the review. Once PEBA's review of the appeal is complete, the subscriber will receive a written determination in the mail.

If the appeal is denied, PEBA will send the subscriber a detailed decision letter explaining the reason(s) for denial. The subscriber will then have 30 days to seek judicial review at the Administrative Law Court, as provided by Section 1-11-710 and 1-23-380 of the SC Code of Laws, as amended.

Accounting and billing

Accounting and billing

This section includes information about the monthly billing statement and other accounting procedures. This is only a guide; it will not cover every situation. If you have questions, call your PEBA Insurance Finance account representative (indicated on your Billing Statement) at 803.734.1696 or at 888.260.9430.

View information about accounting and enrollment reports in the EBS reports reference document.

General accounting rules

Employers are responsible for collecting all premiums and submitting them to PEBA. In relation to this responsibility, an employee authorizes his employer to collect his portion of the premiums for the coverage selected. The employer will be billed and is required to pay all outstanding premiums.

Collecting premiums for mid-month changes

Changes in status

For changes in status effective *on or before the 15th of the month*, collect premiums for that entire month.

For changes in status effective *after the 15th of the month*, start collecting premiums the first of the following month.

Death of employee/subscriber

If terminating coverage due to death of an employee or other subscriber *on or before the 15th of the month*, do not collect premiums for that month.

- Exception: If the employee or other subscriber dies *on the 15th of the month*, coverage will be terminated on the 16th of the month. Collect premiums for the entire month.

If terminating coverage due to death of an employee or other subscriber *after the 15th of the month*, collect premiums for that entire month.

Unpaid leave rules

For more information and policies regarding unpaid leave, refer to the Active subscriber's chapter under unpaid leave or reduction in hours.

In an unpaid leave situation, the employer should be consistent and fair with notification and time allowances on premium payments owed by the employee.

If the employee does not pay the premiums, the employer can terminate the coverage for non-payment of premiums, but only up to 31 days retroactive.

See *Submitting premiums for employees on unpaid leave* for your employer type.

Issuing credits

Not applicable to Comptroller General (CG) agencies

PEBA does not issue individual refunds. Instead, a credit is applied to the billing statement and the employer then refunds the subscriber.

- When a refund of tax-deferred premiums is issued to an employee, the employee's taxable salary should be adjusted for his W-2 records. It is not PEBA's responsibility to confirm this adjustment is made.

Retroactivity

When a coverage election is processed with an effective date prior to the current billing statement month, a charge or credit of premiums is considered retroactive.

Billing statements

Frequency: Monthly

On or before the first of each month, PEBA produces a billing statement in EBS (HAC610) for active subscribers. This PDF billing statement enables you to maintain the accounting records of each employee. If you verify the information on the billing statement and communicate with PEBA whenever there are questions about the

information, the financial process for employees' benefits should work smoothly.

The billing statement includes employer contributions and employee premiums due for all insurance programs..

Group Address page

This page contains the group number, employer name and address, and the billing contact person PEBA will contact if there are any questions. The billing contact person should be the individual responsible for remitting payment for insurance premiums. If there is a change, your Authorizing Agent should update the primary Billing Contact in EBS (under Contacts).

The middle of the page lists your account representative, phone number and PEBA Insurance Finance's return address.

At the bottom of the page, there is a key to assist with the Coverage Processing section of the billing statement.

Account Summary pages

These two pages summarize the prior month's activity, ending with the net premium outstanding from the prior month and the billing for the current month, including any retroactivity.

The Employer Share for health, dental, Basic Life and Basic LTD is rolled into one total. Separate totals are provided for the Employee Share for health, Basic Dental, Dental Plus, Optional Life, Dependent Life-Spouse, Dependent Life-Child, SLTD, State Vision Plan, and the tobacco and e-cigarette use premium. A grand total is provided by adding the total employer and employee shares together.

Beginning Balance lists the Total Net Balance due from the prior month's billing statement.

Payment Transactions lists all payments received since the completion of the prior month's billing statement, including SCEIS payroll deductions (CG agencies only) and returned payments.

Accounting Transactions lists all refunds, canceled refunds and accounting adjustments processed since the prior month's billing statement. There are two types of accounting adjustments: subscriber and employer account.

- *For example*, a subscriber adjustment is processed to correct the effective date of a coverage change. A group account adjustment is processed to correct a payment posted incorrectly.
- If an adjustment is processed for a subscriber, the BIN will be listed on the Account Summary page and an Adjustment form will be sent to the employer. This form will show the amount and explain why the subscriber's account was adjusted.

The Net Premium Outstanding is the total of the Beginning Balance less the Total Payments, plus (+) or minus (-) the Total Adjustments.

The Current Month Billing details are on the Billing Summary pages.

The Retro Summary details are on the Billing Summary and Coverage Processing pages.

The $3/subscriber Administrative Fee is included for optional employers only.

Total Net Balance is the total of the Net Premium Outstanding, Current Month Billing and Retro Summary.

Billing Summary pages

These pages show a breakdown of the current month's bill for each program by employee type (Full-time; Part-time; Non-permanent Full-time; Variable Hours).

The summary itemizes the current month premiums, retroactive premiums and total due, for the employer share and the employee share, of each program. The current month's total number of subscribers enrolled in each of the programs is also included.

Coverage Processing pages

These pages provide a detailed list of enrollments, changes and terminations processed since the completion of the last month's bill. These changes are listed in alphabetical order by the subscriber's last name, with the information displayed only for the program(s) affected by the transaction. If no transactions are processed, this section of the billing statement is not included.

Review each subscriber listed against any transaction processed to confirm it was processed correctly. If there is a discrepancy, contact PEBA.

The first column lists the subscriber's name with the BIN and the date of birth displayed across the page on the same row.

The second column shows which program is affected by the coverage processing entry. View the key on the Group Address page for program help.

The third column lists which plan and coverage level the subscriber elected. The alpha and numeric characters for the various plans are in the key on the Group Address page.

The fourth column shows the effective date.

The next two columns display the employer and employee retroactive premiums and the current rate. The purpose of the current rate is to assist you in reconciling the bill.

The last column (Action) indicates the reason for the transaction.

The grand total for all retroactivity can be found after the last employee listed in the Coverage Processing pages. Retroactivity amounts are also listed on the Account Summary and Billing Summary pages.

Remittance Advice page

This final page of the billing statement includes the total amount due for the current month. This amount is also at the bottom of the Account Summary page.

If you pay via check, return the completed Remittance Advice page with payment to PEBA. See *Submitting premium payments to PEBA* for detailed instructions.

Advance deposit billing statement

Not applicable to Comptroller General (CG) agencies

An advance deposit of at least one month's premium for employer contributions is due to PEBA each year. At the beginning of the fiscal year in July, PEBA bills employers for the advance deposit. Payment is due to PEBA by July 15.

View the advance deposit bill in Online Bill Pay or Accounting Reports (HAC576) of EBS.

The advance deposit bill lists insurance programs for which the employer contributes to the monthly premium (State Health Plan, Basic Dental, Basic Life, Basic LTD) and the subscriber count enrolled in each of these programs at the end of June. The subscriber count is multiplied by the current employer rate to arrive at the deposit amount.

On the last page of the bill, fill in the amount for one-month deposit or more than one-month deposit in the appropriate space. Sign, date and include a telephone number in the space provided.

- A one-month deposit will be credited to the June billing statement, which may result in a balance due or overpayment.
- A more than one-month deposit is credited to your account immediately.

Active billing file

All employers are responsible for reconciling their employer and employee records on a monthly basis. PEBA provides Active Billing Files (HAC450 or HAC460) in EBS. Files are provided in a Text (.txt) format and include demographic and coverage information for subscribers.

The 460 version is broken down into four files, while the 450 version is two larger files containing the same information but formatted to use with CSI payroll software.

- Subscriber Data (HAC450/460)
- Dependent Data (HAC450/460)
- Beneficiary Data (HAC460)
- Other Insurance Data (HAC460)

HAC450 is loaded for all employers unless the HAC460 is requested. Contact your accounting representative if you wish to change to HAC460.

Submitting premium payments to PEBA

Not applicable to Comptroller General (CG) agencies

All balances are due to PEBA on the 10th of the month and must be paid as billed. If there is a keying error on the Coverage Processing pages of the bill, please contact PEBA immediately. If payment is not remitted by the 10th, employers will risk suspension of claims payments for their employees.

- Do not adjust the billing statement.
- Do not delay the regular remittance of monthly premiums due to inability to collect payments from subscribers.
- Employers must pay no less than the current employer share of the premiums for their active employees.
- Do not submit individual checks from your employees. See *Submitting premiums for employees on unpaid leave* for your employer type.

Remit payments to PEBA through one of the three following options:

Online Bill Pay

Processing your payment online through EBS is easy and convenient.

To use this feature:

- Complete a new *EBS Designated Employee Confidentiality Agreement* form and mark Online Bill Pay.
- Log in to your EBS account and verify your email address in the lower right corner on the EBS homepage before submitting a payment. Select the *Update My Email Address* link, if changes are needed.

After you complete these steps, you will be able to complete the following with Online Bill Pay:

- Schedule a payment;
- View the status of your account
- View bill and payment history for previous 12 months; and
- View billing statements for previous 12 months.

Please note, the minimum amount you may pay is your current balance.

Electronic Funds Transfer (EFT)

Electronic Funds Transfer, or automatic draft, gives PEBA authorization to automatically deduct the total amount due, per the monthly billing statement (HAC610), from the designated bank account. The amount will be drafted from the designated bank account on the 10th of the following month. If the 10th falls on a weekend or holiday, the draft will occur on the next business day.

To enroll in EFT payments, complete an *Authorization Agreement for Electronic Funds Transfer*. Submit this form with a voided check from the designated bank account. After PEBA receives the authorization, it will take about 31 days for the automatic draft to begin.

By check

Please allow additional time for processing of paper checks. All checks should be made payable to PEBA. See more information about check payments for your employer type in the next section.

You must return a completed Remittance Advice form with every payment. See *Billing Statement* for information about the Remittance Advice.

If you are submitting more than one check, list the amount of each check on the right side of the Remittance Advice. Verify the total check amounts equal the total amount due. Sign, date and provide a telephone number in the appropriate spaces.

Do not return any other section of the billing statement with your payment.

Mail your payment to the following mailing address:

S.C. PEBA
Attn: Insurance Finance Department
P.O. Box 11661
Columbia, SC 29211

See also the premium checks quick reference on Page 180.

MoneyPlus payrolls and accounting

Each employer is responsible for reporting the actual amount of each payroll deduction every payroll cycle to ASIFlex. View the *MoneyPlus Employer Payroll User Quick Guide* for details about the ASIFlex employer portal, processing payroll deduction files, reviewing and responding to discrepancy reports, and more.

To post contributions to participant accounts, ASIFlex must receive the funding from each employer in a timely manner. The employer should send actual funds via ACH to ASIFlex three business days prior to the actual pay date. View the *Quick Guide* for details.

For optional employers

Administrative fee

Optional employers must pay a $3 administrative fee for each active employee, retiree, survivor and COBRA participant per month. Employers cannot pass this fee to active employees and COBRA participants. An employer may require retirees and survivors to pay this fee.

Experience rating health premiums

Optional employers are subject to experience rating of health insurance premiums. The experience rating load factor or a percentage amount is added to the optional employer's health premiums based on claims history. This factor is adjusted each year.

PEBA calculates the experience rating load factor of all optional employers annually. Employers will receive written notification of their load factor each March, and the factor will be applied in January of the following year to both the employer and employee premiums.

The employer may choose to absorb some or all of any increase in the employee share. However, an employer may **not** pass along any of the employer share of the increase to the employee. The employer is responsible for notifying its subscribers of any rate changes. Employer contributions and employee premiums may be different than those published in PEBA publications. Use the fillable optional employer premium worksheet.

Rate changes due to experience rating are separate and are in addition to any annual, across-the-board rate increases that are announced each fall for the upcoming plan year.

When optional employers initially join the State insurance benefits program, they are categorized by their number of covered lives (number of individuals insured under the program).

- **Small:** Fewer than 100 covered lives. Rated according to average claims experience of all the small employers.
- **Medium:** 100-500 covered lives. Once 24 months of claims are incurred for an employer, rated using a formula that gives 50 percent weight to the average claims experience of all medium employers combined and 50 percent weight to the claims experience of the individual employer.
- **Large:** More than 500 covered lives. Once 12 months of claims are incurred for an employer, rated solely on the claims experience of that employer.

See the *Optional Employer Handbook* for complete details about experience rating load factors. A history of load factors is also available.

View information about two reports that detail updated health insurance premiums in the EBS reports reference document.

- Active Rate with Load Factor (HTB527)
- Individual Rate with Load Factor (HTB528)

Retiree, COBRA and Survivor premiums

The optional employer continues to serve as the benefits administrator for these subscribers; therefore, the employer will receive the monthly Retiree, COBRA and Survivor bill (HRA610) in EBS.

The PDF billing statement is the same as that for active subscribers. Note that some programs are not listed, because they are not available to these subscribers. The $3 administrative fee for each retiree, survivor and COBRA participant per month is included on the Account Summary pages.

Collect the premiums for covered retirees, COBRA and survivor subscribers and deposit their checks into your account. Their checks should be made payable to the employer, **not** PEBA. Do not submit personal checks to PEBA.

Subscriber questions regarding the premium amounts or billing should be directed to the employer.

A single check should be remitted from the employer for the total amount due shown on the Remittance Advice page of the individual and active group bills.

Retiree, COBRA and Survivor Roster

This monthly PDF or CSV-formatted roster (HRA500) provides information on each retiree, COBRA and survivor subscriber's coverage, and the monthly employee premium for each program:

- State Health Plan;
- Basic Dental;
- Dental Plus;
- Vision; and
- Tobacco and e-cigarette use premium.

The roster is divided into sections based on subscriber type (18-month COBRA, 29-month COBRA, 36-month COBRA, Retiree-Regular, Retiree-25 Year, Survivor, etc.).

In each of the sections, names are printed in alphabetical order by last name, first name and middle initial, with the BIN listed in the next column. This roster will not include Social Security numbers.

Submitting premiums for employees on unpaid leave

Premiums for employees on unpaid leave are included on the monthly billing statement (HAC610).

Collect the total monthly premium due for employees on unpaid leave. Personal checks should be made payable to the employer, **not** PEBA. Deposit the collected unpaid leave premiums into your employer account and include the premiums in your monthly payment. Do not submit employee personal checks to PEBA.

For school districts and public higher education institutions

Retiree, COBRA and Survivor premiums

PEBA becomes the benefits administrator for these subscribers. The subscriber, not the employer, will receive a bill from PEBA.

Personal checks, payable to PEBA, must be submitted to PEBA with the bill. Retirees, who have their premiums deducted from their retirement checks or auto-drafted from a bank account, do not receive a bill.

Submitting premiums for employees on unpaid leave

Premiums for employees on unpaid leave are included on the monthly billing statement (HAC610).

Collect the total monthly premium due for employees on unpaid leave. Personal checks should be made payable to the employer, **not** PEBA. Deposit the collected unpaid leave premiums into your group account and include the premiums in your monthly payment. Do not submit employee personal checks to PEBA.

For Comptroller General (CG) agencies only

Retiree, COBRA and Survivor premiums

PEBA becomes the benefits administrator for these subscribers. The subscriber, not the CG agency, will receive a bill from PEBA.

Personal checks, payable to PEBA, must be submitted to PEBA with the bill. Retirees, who have their premiums deducted from their retirement checks or auto-drafted from a bank account, do not receive a bill.

Submitting premiums for employees on unpaid leave

Premiums for employees on unpaid leave are included on the monthly billing statement (HAC610).

Collect the total monthly premium due for employees on unpaid leave. Make sure the personal check(s) includes the employee's BIN. Submit the personal checks from the employees on unpaid leave, along with a personal checks form of the plans/coverage for each.

If you do not collect the monthly premium from a subscriber while he is in unpaid leave status, SCEIS will collect the total amount due from the first payroll check the subscriber receives once he is no longer in unpaid leave status. If you remit the monthly premiums, you should notify SCEIS that the payments have been sent to PEBA so they will not deduct the incorrect amount. SCEIS will continue to remit the monthly employer premiums for the subscriber while he is in unpaid leave status.

See Page 179 for more information on unpaid leave rules.

Payroll reconciliation report

PEBA sends an enrollment file to SCEIS daily. SCEIS uses the information on the file (benefit, effective date, type of entry, coverage level and premium) to determine the premiums to be deducted on the next payroll. The reconciliation reports are a comparison of the enrollment files at PEBA and the SCEIS payroll deductions.

PEBA provides a monthly reconciliation (Employee-HAC402; Employer-HAC403) of monthly premiums to all CG agencies. The reconciliation for the previous month is forwarded to the agency with the current month's billing statement.

The employee reconciliation report (HAC402) lists the subscriber(s) who is being billed a different amount than the deducted premium, in the following order:

- State Health Plan and the GEA TRICARE Supplement Plan;
- Basic Dental;
- Dental Plus;
- Optional Life;
- Dependent Life-Child;
- Dependent Life-Spouse;
- SLTD;
- State Vision Plan; and
- Tobacco and e-cigarette surcharge.

The employer reconciliation report (HAC403) lists the subscriber(s) for which the employer is billed a different amount than the SCEIS employer contribution, in the following order:

- State Health Plan and the GEA TRICARE Supplement Plan ($ per coverage level);
- Basic Dental ($13.48);
- Basic LTD ($3.22); and
- Basic Life ($0.32).

Insurance Master is the premium amount per PEBA's enrollment records. SCEIS Deduction is the premium amount that is payroll deducted. The final column is the difference between the two amounts. A summary for each program is included.

Research each difference and take proper action to correct any problem(s).

SCEIS payroll process

SCEIS collects and remits to PEBA the employer and employee premiums based on the daily enrollment file. You may view your monthly billing statement (HAC610); however, you should not remit payment for the monthly premiums. See *Billing Statement* for details about the monthly bill.

Contact the SCEIS Help Desk with questions concerning which account the employer premiums are taken from or the funding source for the employer premiums.

If you discover an enrollment error on the billing statement, contact PEBA to resolve the error, which should correct the deduction. If the coverage is correct but the payroll deductions are not, contact the SCEIS Help Desk.

For a new hire or coverage change that results in a large balance due, premiums may be collected over several pay periods. Contact the SCEIS Help Desk to change the amount of the deduction and the number of pay periods.

Refunds are a reimbursement of overpaid insurance premiums to the employee, or to the employer in certain situations.

SCEIS will not process a refund check for amounts less than $1; therefore, an adjustment must be requested to zero out an employee's balance.

Unclaimed refund checks

If the U.S. Postal Service returns a refund check to your employer as undeliverable, the check, along with the envelope returned from the U.S. Postal Service stating it was unable to deliver the refund check, should be forwarded to PEBA. The overpayment of premiums will become a part of the Unclaimed Property maintained by the Office of the State Treasurer. Former employees can search by their name to locate any unclaimed funds due to them at treasurer.sc.gov.

Reports

PEBA provides several reports in EBS. Details about each report are available in the EBS reports reference document.

Annual SLTD salary updates

Not applicable to Comptroller General (CG) agencies

All salaries must be reviewed and updated annually during open enrollment. You may begin entering the salaries in EBS on September 15. Please submit this information to PEBA no later than October 31.

To update SLTD premiums correctly for the next plan year, PEBA needs updated salary information for your employees who are enrolled in SLTD. The salary on which SLTD premiums are based should include the employee's base rate of pay for the hours they are regularly scheduled to work, plus any of the following that apply to the employee:

- Longevity pay;
- Shift differential pay;
- Regular compensation earned by university teaching staff during regular summer sessions; and
- Contributions the employee makes to deferred compensation plans or fringe benefits (like payroll deductions for health insurance).

Do not include overtime pay, commissions, bonuses, employer contributions to benefits or any other extra compensation.

If you do not update the salary information, premiums, and any benefits paid, will be based on the most recent salary information submitted to PEBA.

Update salaries for any employee who has had a salary change since the previous October 1.

Example: If an employee was hired March 2021 with a salary of $25,000, and he has received a salary increase of $3,000, and his salary as of October 1 includes this increase, you must submit the updated salary of $28,000 to PEBA in October 2021.

The maximum annual salary for calculating SLTD benefits and premiums is $147,684. If PEBA receives any salary updates that exceed this amount, the updated salary will default to the maximum.

Employers who implement furloughs should use employees' non-furlough salaries to calculate premiums.

In EBS, select SLTD Salary Entry under Manage Groups. Use one of the methods listed below:

- Select SLTD Salary Browse to add employee salaries individually. Enter the data into each field and click on the button at the bottom of the screen to submit the information for each employee.
- Upload SLTD data text file.
- Download SLTD Coverage Data. This list includes all employees enrolled in SLTD at the time of your request. Follow the instructions to create a new text document, and then select Upload SLTD Data to upload your revised file to EBS.
- Select the Batch Entry Screen, which allows you to enter 10 employee salaries at a time.

Select Current SLTD Coverage List to receive a list of all employees currently enrolled in SLTD. Review and Confirm all SLTD salary entries when you've completed updates for your employer.

For more details, view the SLTD tutorial video at peba.sc.gov/insurance-training. If you have any questions about submitting SLTD salary information, contact PEBA.

Affordable Care Act

The Patient Protection and Affordable Care Act, also known as the Affordable Care Act (ACA), is the health reform legislation signed into law in March 2010. Key provisions of the legislation include extending coverage to millions of uninsured Americans, implementing measures that will lower health care costs and eliminating industry practices that include denial of coverage due to preexisting conditions.

The ACA does not require businesses to provide health benefits to their workers, but applicable large employers may face penalties if they don't make affordable coverage available. The Employer Shared Responsibility Provision of the ACA penalizes employers who either do not offer coverage or do not offer coverage that meets minimum value and affordability standards.

As a participating employer in PEBA insurance benefits, you must offer coverage to all employees eligible to participate in the insurance benefits. The *Plan of Benefits* document has been amended to allow coverage for permanent full-time employees, as well as non-permanent full-time employees and variable-hour, part-time and seasonal employees.

PEBA offers "grandfathered health plans" under the ACA. As a grandfathered plan, PEBA will be able to minimize the increase in State Health Plan premiums while it assesses the future financial impact of the act. As permitted by the ACA, a grandfathered health plan can preserve certain basic health coverage that was already in effect when the law was enacted.

Being a grandfathered health plan means that the plan may not include certain consumer protections of the ACA that apply to other plans, such as the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the ACA, such as the elimination of lifetime limits on benefits.

For ACA resources, including frequently asked questions and reporting requirements, go to peba.sc.gov/aca.

Nondiscrimination testing

To remain tax free under Internal Revenue Code sections 105, 125 and 129, the MoneyPlus plan must pass several nondiscrimination tests.

One of these tests, the 55 percent Average Benefits Test, requires that all eligible employees' gross compensation be collected. This test is vital in determining the South Carolina MoneyPlus plan's compliance with Internal Revenue Service (IRS) nondiscrimination rules.

PEBA will perform this test within the first 60 days of any given plan year.

This is for your information only. PEBA will contact you directly if they need any information for the purpose of nondiscrimination testing.

Imputed income (taxable portion of Optional Life premiums)

Optional Life insurance coverage in excess of $50,000 is considered imputed income (taxable) by the IRS when the premium for this coverage is paid through the MoneyPlus Pretax Group Insurance Premium feature. The imputed income is based on an employee's age and amount of Optional Life coverage in excess of $50,000. It is added to the employee's salary and is subject to federal income tax and FICA. The taxable portion of the Optional Life coverage will always be the amount over $50,000 of the total coverage, regardless of any employer contributions.

Imputed income rate table (2021 tax year)

Age category	Rate per $1,000 in coverage beyond $50,000
Younger than 25	0.05
25-29	0.06
30-34	0.08
35-39	0.09
40-44	0.10
45-49	0.15
50-54	0.23
55-59	0.43
60-64	0.66
65-69	1.27
70 and older	2.06

Imputed income is calculated based on the IRS rate table above. The IRS may change these rates periodically. Each $1,000 of Optional Life coverage beyond $50,000 is multiplied by the monthly rate for the applicable age group.

Example: An employee, who elected $180,000 in Optional Life coverage, turns age 40 in October 2020. His monthly Optional Life premium on $180,000 in coverage is $14.04, based on his age category the previous December 31.

His imputed income would be calculated like this:

1. $180,000-$50,000 = $130,000
2. $130,000 ÷ 1,000 = $130 (the per-thousand amount)
3. 130 × 0.10 (the rate for the age 40-44 category from the IRS rate table) = $13.00

per month. This is the taxable monthly amount of imputed income.

This monthly amount may be multiplied by 12 to get an annual amount. The employer is responsible for reporting the imputed income amounts on employees' W-2 forms.

On a monthly basis, PEBA provides the Optional Life Taxable/Non-taxable Change File (HAC998) and prior to the new plan year, after open enrollment changes have been updated, PEBA will provide the OL Taxable/Non-taxable Premiums File (HAC999). Files include employees enrolled with Optional Life coverage over $50,000. View information about these reports in the EBS reports reference document.

At the end of the year, PEBA will provide the YTD Imputed Income Report (HAC996) so you can adjust the employees' W-2 forms accordingly. View information about this report in the EBS reports reference document.

Your employer may choose to deduct the taxable and non-taxable premium amounts separately each pay period. If your employer accounts for the taxable portion of the OL premiums for employees throughout the year on all payrolls, you will need to use only the YTD Imputed Income Report (HAC996) for comparison purposes.

Important reminders in calculating imputed income

Imputed income for employees who were enrolled only part of the year should be prorated.

Unlike calculating PEBA OL premiums, which are based on the employee's age category as of the *previous* December 31, imputed income is calculated by the IRS, based on the employee's age category as of December 31 of the *current* year.

- For example, for the 2020 tax year, if an employee turns age 50 in September, his IRS-imputed income for 2020 is based on the rate for the 50-54 age category in the IRS rate table, even though his 2020 OL premium is based on the age 45-49 category.

Instead of one age category for OL premiums for those younger than 35, there are three age categories in the IRS rate table for those younger than 35:

- Younger than 25;
- 25-29; and
- 30-34.

The last category in the IRS rate table is for those ages 70 and older whereas the last age category for OL premiums is 80 and older.

Reclassification of outstanding MoneyPlus debit card transactions

Reclassification report

Each fall, ASIFlex will send benefits administrators a payback report that lists any employees with outstanding debit card transactions from the previous plan year. This report shows each individual transaction (by SSN and name) and the total amount due.

Employees who are on this report have received multiple notifications about the outstanding transaction(s), including a final notice sent by September 1 to provide documentation.

Reclassification

The unsubstantiated amounts must be reclassified as taxable income, and that employee's W-2 must be amended to reflect that amount.

Example: For the 2020 plan year, an employee has an outstanding card transaction of $50. That employee has until March 31, 2021, to clear up the expense by:

- Submitting the necessary documentation to substantiate the claim;

- Filing a paper claim or claims that will offset the outstanding card transaction amount; or
- Writing a check made payable to the State of South Carolina and mailing it to ASIFlex, SC MoneyPlus, P.O. Box 6044, Columbia, MO 65205-6044. This check will repay his account for the amount of the outstanding card transaction amount.

If the outstanding transaction amount is not cleared up by one of these methods, the amount is taxable as income. Since this amount cannot be confirmed until after the end of the tax-reporting period (April 15, 2022), the amount will be reported for the 2021 tax year. In November 2022, ASIFlex will post a report on its employer portal that will include the employee's name and the amount to be added to his taxable income on his 2021 W-2, which will be issued to him in early 2023.

For CG agencies, ASIFlex will send a file to the Comptroller General's Office to include the unsubstantiated amounts on the employee's W-2. Your accountant/auditor can discuss the proper W2 application.

Reference

Reference

Acronyms used in this manual

Acronym	Explanation
AD&D	Accidental Death & Dismemberment
BA	Benefits administrator
BlueCross	BlueCross BlueShield of South Carolina
BIN	Benefits ID number (subscriber identification number in lieu of SSN)
BLTD	Basic Long Term Disability
CBA	Companion Benefit Alternatives
CG	Comptroller General
COBRA	Consolidated Omnibus Budget Reconciliation Act
DCSA	Dependent Care Spending Account (MoneyPlus)
DHHS	Department of Health and Human Services (Medicaid)
DSS	Department of Social Services
EBS	Employee Benefits Services
ERISA	Employee Retirement Income Security Act of 1974
FSA	Flexible Spending Account (MoneyPlus)
FMLA	Family and Medical Leave Act of 1993
GEA	Government Employees Association, sponsor of the TRICARE Supplement Plan
HIPAA	Health Insurance Portability and Accountability Act of 1996
HMO	Health Maintenance Organization
HSA	Health Savings Account
IBG	*Insurance Benefits Guide*
LTC	Long term care
LTD	Long term disability
MSA	Medical Spending Account (MoneyPlus)
NOE	*Notice of Election*
PEBA	Public Employee Benefit Authority
PCP	Primary care physician
PPACA (ACA)	Patient Protection and Affordable Care Act of 2010
RETRO	Retroactivity
SCEIS	South Carolina Enterprise Information System
SLTD	Supplemental long-term disability
SOC	Summary of change
SOE	Summary of enrollment
SOI	Summary of intent
SSN	Social Security number
STARS	Statewide Accounting and Reporting System
SVP	State Vision Plan
URT	Unrequested refund transfer
USERRA	Uniformed Services Employment and Reemployment Rights Act of 1994

County codes

1	Abbeville
2	Aiken
3	Allendale
4	Anderson
5	Bamberg
6	Barnwell
7	Beaufort
8	Berkeley
9	Calhoun
10	Charleston
11	Cherokee
12	Chester
13	Chesterfield
14	Clarendon
15	Colleton
16	Darlington
17	Dillon
18	Dorchester
19	Edgefield
20	Fairfield
21	Florence
22	Georgetown
23	Greenville
24	Greenwood
25	Hampton
26	Horry
27	Jasper
28	Kershaw
29	Lancaster
30	Laurens
31	Lee
32	Lexington
33	McCormick
34	Marion
35	Marlboro
36	Newberry
37	Oconee
38	Orangeburg
39	Pickens
40	Richland
41	Saluda
42	Spartanburg
43	Sumter
44	Union
45	Williamsburg
46	York
99	Out-of-state

Quick reference charts

Active NOE quick reference

Use EBS when permissible. Instructions for the *Active Notice of Election* form are on Page 3 of the form. This chart includes specific details for additions and changes. Each column in the table represents a unique event.

NOE section	New hire	Open enrollment	Marriage	Divorce/separation
ACTION	Select: New Hire/Election. Type of Change: Enrollment.	Select: Change. Type of Change: Enrollment.	Select: Change. Type of Change: Other (Specify Marriage and Date of Change Event). Must provide documentation.	Select: Change. Type of Change: Other (Specify Divorce and Date of Change Event). Must provide documentation.
BA USE ONLY	Effective Date; Group ID#; Group Name; if 20-hour employee; Pay periods per year.	Effective Date; Group ID#; Group Name; Pay periods per year.	Effective Date; Group ID#; Group Name; Pay periods per year.	Effective Date; Group ID#; Group Name; Pay periods per year.
ENROLLEE INFO	#1-19	#1-5	#1-5; #8-17	#1-5; #8-17
COVERAGE	#20-26	#20-22, 23-24, 26, if applicable.	#20-24, 26 if changing coverage level.	#20-24, 26 if changing coverage level.
MONEYPLUS Pretax Premiums	Refuse or Yes.	Complete if changing election.	Complete if changing election.	Complete if changing election.
MONEYPLUS Elections	Complete if enrolling.	Complete if re-enrolling or enrolling.	Complete if changing election.	Complete if changing election.
EMPLOYEE INITIALS	Initial and date.	Initial and date.	Initial and date.	Initial and date.
MEDICARE	Complete all, if applicable.	Complete all, if applicable.	Complete all, if applicable.	Complete all, if applicable.
For beneficiaries and dependents: Do not list “spouse” or “child.” List relationship as wife, husband, daughter, son. **For beneficiaries:** An estate or trust has no relationship.				
BENEFICIARIES	Complete all.	Employee option to change; complete all, if applicable.	Employee option to change; complete all, if applicable.	Employee option to change; complete all, if applicable.
DEPENDENTS	Complete all, if applicable.	Complete all, if applicable.	Add; complete all, listing dependents to add.	Delete; listing dependents to delete.
CERTIFICATION & AUTHORIZATION	#31-32	#31-32	#31-32	#31-32

Active NOE quick reference (cont.)

NOE section	Ineligible child/coverage change	Last ineligible child/coverage change	Returning student	Dependent Life-Spouse coverage with medical approval
TYPE OF CHANGE	Select: Change. Type of Change: Other (Specify ineligible child and give reason).	Select: Change. Type of Change: Other (Specify ineligible child and give reason).	Select: Change. Type of Change: Other (Specify returning student). Must provide documentation.	Select: Change. Type of Change: Other (Specify Dependent Life and increase with medical approval). Must provide approval from MetLife.
BA USE ONLY	Effective Date; Group ID#; Group Name.	Effective Date; Group ID#; Group Name.	Effective Date; Group ID#; Group Name.	Effective Date; Group ID#; Group Name.
ENROLLEE INFO	#1-5	#1-5	#1-5	#1-5
COVERAG	#20-22 and 26 if decreasing coverage level.	#20-22 and 26 if decreasing coverage level.	#20-22 and 26 if decreasing coverage level.	#23
MONEYPLUS Pretax Premiums	Complete if changing election.	Complete if changing election.	Complete if changing election.	N/A
MEDICARE	Complete all, if applicable.	Complete all, if applicable.	Complete all, if applicable.	Complete all, if applicable.
For beneficiaries and dependents: Do not list “spouse” or “child.” List relationship as wife, husband, daughter, son. **For beneficiaries:** An estate or trust has no relationship.				
BENEFICIARIES	Employee option to change; complete all, if applicable.	Employee option to change; complete all, if applicable.	Employee option to change; complete all, if applicable.	Employee option to change; complete all, if applicable.
DEPENDENTS	Delete; list child to delete.	Delete; list child to delete.	Add; complete all, listing child to add.	Add; listing spouse.
CERTIFICATION & AUTHORIZATION	#31-32	#31-32	#31-32	#31-32

Active NOE quick reference (cont.)

NOE section	Optional Life add/increase	Optional Life add/increase with medical approval	Optional Life decrease/ refuse	Dependent Life add/increase with medical approval	SLTD add/decrease waiting period with medical approval
TYPE OF CHANGE	Select: Change. Type of Change: Other (Specify OL add or increase and give reason).	Select: Change. Type of Change: Other (Specify OL add or increase with medical approval). Must provide approval from MetLife.	Select: Change. Type of Change: Other (Specify OL decrease or refuse and give reason for change if on Pretax Feature).	Select: Change. Type of Change: Other (Specify DL add or increase with medical approval). Must provide approval from MetLife.	Select: Change. Type of Change: Other (Specify: SLTD add or wait period). Must provide approval from The Standard.
BA USE ONLY	Effective Date; Group ID#; Group Name.	Effective Date; Group ID#; Group Name.	Effective Date; Group ID#; Group Name.	Group ID#; Group Name.	Group ID#; Group Name.
ENROLLEE INFO	#1-5; 18	#1-5; 18	#1-5	#1-5; 18	#1-5, 18
COVERAGE	#24 (enter new amount).	#24 (enter new amount).	#24 (enter new amount or refuse).	#22 for child(ren), #23 (enter new amount).	#25
MONEYPLUS Pretax premiums	Complete if changing election.	Complete if changing election by choosing either yes or refuse.	Complete if changing election.	N/A	N/A
MEDICARE	Complete all, if applicable.	Complete all, if applicable.	Complete all, if applicable.	Complete all, if applicable.	Complete all, if applicable.
For beneficiaries: Do not list “spouse” or “child.” List relationship as wife, husband, daughter, son. An estate or trust has no relationship.					
BENEFICIARIES	Employee option to change; complete all, if applicable.	Employee option to change; complete all, if applicable.	Employee option to change; complete all, if applicable.	Employee option to change; complete all, if applicable.	Employee option to change; complete all, if applicable.
DEPENDENTS	N/A	N/A	N/A	N/A? #30	N/A
CERTIFICATION & AUTHORIZATION	#31-32	#31-32	#31-32	#31-32	#31-32

Special eligibility situations quick reference

This information describes changes subscribers can make when a special eligibility situation occurs. Unless otherwise noted, all changes must be made within 31 days of the event.

Event	This person/these people *(select one)*	Can do one or more of these actions *(select as many as apply)*	Effective date	Documentation required
Birth of child	☐ Employee alone ☐ Employee and newborn child ☐ Employee and existing child(ren) ☐ Employee and spouse ☐ Employee, spouse, existing child(ren) and newborn child	☐ Enroll in health (if employee already enrolled in health, may change plans if adding spouse or child to health) ☐ Enroll in dental ☐ Enroll in State Vision ☐ Enroll in Dependent Life-Child ☐ Enroll in or increase Dependent Life-Spouse ($10,000 or $20,000 without evidence of insurability; more than $20,000 with evidence of insurability) ☐ Enroll in or increase Optional Life (up to $50,000 without evidence of insurability; more than $50,000 with evidence of insurability) ☐ Review changes available with MSA/DCSA	**Health, dental and vision:** Date of birth **Optional Life and Dependent Life-Spouse:** For amounts available without medical evidence, first of month following date of request. For amounts requiring evidence of insurability, first of month following date of approval. **Dependent Life-Child:** Date of birth	Long-form birth certificate of child **and** if adding spouse, marriage license or Page 1 of latest tax return.
	Notes			
	A. Note about premiums: If the employee is enrolled in the MoneyPlus Pretax Group Insurance Premium feature, premiums may be paid pretax beginning the first of the month following the date of the request. B. May not drop any coverage; may only change or add coverage. C. For Optional Life, if employee is not actively at work on the expected effective date, then the effective date will be first of the month following return to work. For Dependent Life, if dependent, other than a newborn, is confined to a hospital or elsewhere on the expected effective date, then the effective date will be deferred until the spouse or child is discharged from the hospital or no longer confined.			

Special eligibility situations quick reference (cont.)

Event	This person/these people *(select one)*	Can do one or more of these actions *(select as many as apply)*	Effective date	Documentation required
Adoption of child (or placement for adoption)	☐ Employee alone ☐ Employee and newly adopted child ☐ Employee and existing child(ren) ☐ Employee and spouse ☐ Employee, spouse, existing child(ren) and newly adopted child	☐ Enroll in health (if employee already enrolled in health, may change plans if adding spouse or child to health) ☐ Enroll in dental ☐ Enroll in State Vision ☐ Enroll in Dependent Life-Child ☐ Enroll in or increase Dependent Life-Spouse ($10,000 or $20,000 without evidence of insurability; more than $20,000 with evidence of insurability) ☐ Enroll in or increase Optional Life (up to $50,000 without evidence of insurability; more than $50,000 with evidence of insurability) ☐ Review changes available with MSA/DCSA	**Health, dental and vision:** Date of adoption or placement for adoption, UNLESS baby is adopted or placed for adoption within 31 days of birth — then date of birth. **Optional Life and Dependent Life-Spouse:** For amounts available without medical evidence, first of month following date of request. For amounts requiring evidence of insurability, first of month following date of approval. **Dependent Life-Child:** Date of birth for newborns. First of the month after date of request for other children.	Long-form birth certificate listing the subscriber as the parent; legal adoption documentation from court, verifying adoption completed; or letter of placement from adoption agency, attorney, or DSS verifying adoption in progress **and** if adding spouse, marriage license or Page 1 of latest tax return.
	Notes			
	A. Note about premiums: If the employee is enrolled in the MoneyPlus Pretax Group Insurance Premium feature, premiums may be paid pretax beginning the first of the month following the date of the request. B. May not drop any coverage; may only change or add coverage. C. For Optional Life, if employee is not actively at work on the expected effective date, then the effective date will be first of the month following return to work. For Dependent Life, if dependent, other than a newborn, is confined to a hospital or elsewhere on the expected effective date, then the effective date will be deferred until the spouse or child is discharged from the hospital or no longer confined.			

Special eligibility situations quick reference (cont.)

Event	This person/these people *(select one)*	Can do one or more of these actions *(select as many as apply)*	Effective date	Documentation required
Placement of foster child (with court order) *If you have gained legal custody of your foster child, see Gains custody of child*	☐ Employee alone ☐ Employee and new foster child ☐ Employee and existing child(ren) ☐ Employee and spouse ☐ Employee, spouse, existing child(ren) and new foster child	☐ Enroll in health (if employee already enrolled in health, may change plans if adding spouse or new foster child to health) ☐ Enroll in dental ☐ Enroll in State Vision ☐ Review changes available with MSA/DCSA	**Health, dental and vision** Date of placement (usually date of court order).	Court order placing child in foster care with the employee **and** if adding spouse, marriage license or Page 1 of latest tax return.
	Notes A. Note about premiums: If the employee is enrolled in the MoneyPlus Pretax Group Insurance Premium feature, premiums must be paid post-tax for retroactive coverage back to the date of gaining custody or guardianship. Premiums may be paid pretax beginning the first of the month following the date of the request. B. May not drop any coverage; may only change or add coverage.			

Special eligibility situations quick reference (cont.)

Event	This person/these people *(select one)*	Can do one or more of these actions *(select as many as apply)*	Effective date	Documentation required
Gains custody of child (with court order)	☐ Employee alone ☐ Employee and child for whom he gained legal custody ☐ Employee and existing child(ren) ☐ Employee and spouse ☐ Employee, spouse, existing child(ren) and child for whom he gained legal custody	☐ Enroll in health (if employee already enrolled in health, may change plans if adding spouse or child to health) ☐ Enroll in dental ☐ Enroll in State Vision ☐ Review changes available with MSA/DCSA	**Health, dental and vision** Date of court order	Court order granting custody of the child to employee **and** if adding spouse, marriage license or Page 1 of latest tax return.
	Notes			
	A. Note about premiums: If the employee is enrolled in the MoneyPlus Pretax Group Insurance Premium feature, premiums must be paid post-tax for retroactive coverage back to the date of gaining custody or guardianship. Premiums may be paid pretax beginning the first of the month following the date of the request. B. May not drop any coverage; may only change or add coverage. C. For Dependent Life, if dependent, other than a newborn, is confined to a hospital or elsewhere on the expected effective date, then the effective date will be deferred until the spouse or child is discharged from the hospital or no longer confined.			

Special eligibility situations quick reference (cont.)

Event	This person/these people *(select one)*	Can do one or more of these actions *(select as many as apply)*	Effective date	Documentation required
Marriage	☐ Employee alone ☐ Employee and any new stepchild ☐ Employee and existing child(ren) ☐ Employee and spouse ☐ Employee, spouse, existing child(ren) and any new stepchild	☐ Enroll in health (if employee already enrolled in health, may change plans if adding spouse or stepchild to health) ☐ Enroll in dental ☐ Enroll in State Vision ☐ Enroll in Dependent Life-Spouse ($10,000 or $20,000 without medical evidence; more than $20,000 with evidence of insurability) ☐ Enroll in Dependent Life-Child ☐ Enroll in or increase Optional Life (up to $50,000 without evidence of insurability; more than $50,000 with evidence of insurability) ☐ Review changes available with MSA/DCSA	**Health, dental and vision:** Date of marriage **Optional Life and Dependent Life-Spouse:** For amounts available without medical evidence , first of month following date of request. For amounts requiring medical evidence , first of month following date of approval. **Dependent Life-Child:** First of the month after date of request.	Marriage license **and** if adding stepchildren, also need long-form birth certificates for each child.
	Notes			
	A. Note about premiums: If the employee is enrolled in the MoneyPlus Pretax Group Insurance Premium feature, premiums must be paid post-tax for retroactive coverage back to the date of marriage. Premiums may be paid pretax beginning the first of the month following the date of the request. B. May not drop any coverage; may only change or add coverage. C. For Optional Life, if employee is not actively at work on the expected effective date, then the effective date will be first of the month following return to work. For Dependent Life, if dependent, other than a newborn, is confined to a hospital or elsewhere on the expected effective date, then the effective date will be deferred until the spouse or child is discharged from the hospital or no longer confined.			

Special eligibility situations quick reference (cont.)

Event	This person/these people *(select one)*	Can do one or more of these actions *(select as many as apply)*	Effective date	Documentation required
Divorce	☐ Former spouse and any former stepchildren	☐ The employee must drop former spouse and stepchildren from health, dental and vision. ☐ Must drop Dependent Life for former spouse or stepchild, even if court ordered to continue. ☐ If divorce decree requires the employee to continue coverage for former spouse, former spouse can enroll in own coverage using the *Former Spouse NOE*.	**Health, dental and vision:** First of month following divorce **Dependent Life:** Date of divorce **Exception to 31-day rule:** If dropping ineligible spouse or stepchildren and PEBA is notified more than 31 days after divorce, first of month following notification.	First page of divorce decree and signature page
	☐ Employee	☐ Enroll in or increase Optional Life up to $50,000 without evidence of insurability ☐ Cancel or decrease Optional Life ☐ Review changes available with MSA	**Optional Life:** If employee is actively at work, first of month following date of request. If not actively at work, first of month following return to work.	
	Notes			
	A. May not drop health, dental or vision coverage for himself or any dependents who remain eligible for coverage. B. For Optional Life, if employee is not actively at work on the expected effective date, then the effective date will be first of the month following return to work.			

Special eligibility situations quick reference (cont.)

Event	This person/these people *(select one)*	Can do one or more of these actions *(select as many as apply)*	Effective date	Documentation required
Employee loses other health coverage (includes Medicare)	If employee is not already enrolled in PEBA's health coverage: ☐ Employee ☐ Employee and spouse ☐ Employee and children ☐ Employee, spouse and children	☐ Enroll in health ☐ Enroll in dental ☐ Enroll in State Vision	**Health, dental and vision:** Date of loss of health coverage	Verifiable confirmation from prior employer (letter, email, etc.) stating employee lost health coverage and date of loss **and** long-form birth certificate if adding child; marriage license or Page 1 of latest tax return if adding spouse.
	If employee is already enrolled in PEBA health coverage: Not eligible to change elections.	Not eligible to change elections.		
	Notes			
	A. Note about premiums: If the employee is enrolled in the MoneyPlus Pretax Group Insurance Premium feature, premiums must be paid post-tax for retroactive coverage back to the date of loss of coverage. Premiums may be paid pretax beginning the first of the month following the date of the request. B. Letter does NOT have to state employee lost dental or vision to add dental or vision. C. Letter does not have to state spouse or children lost coverage to add them. D. May not drop any coverage but may add coverage.			

Special eligibility situations quick reference (cont.)

Event	This person/these people *(select one)*	Can do one or more of these actions *(select as many as apply)*	Effective date	Documentation required
Spouse or child loses other health coverage (includes Medicare)	☐ Employee and spouse/child who lost health coverage	☐ Enroll in health (if employee already enrolled in health, may change plans if adding spouse or child to health) ☐ Enroll in dental ☐ Enroll in State Vision	**Health, dental and vision:** Date of loss of health coverage	Verifiable confirmation from prior employer (letter, email, etc.) stating spouse/child lost health coverage and date of loss **and** long-form birth certificate if adding child; marriage license or Page 1 of latest tax return if adding spouse.
	Notes			
	A. Note about premiums: If the employee is enrolled in the MoneyPlus Pretax Group Insurance Premium feature, premiums must be paid post-tax for retroactive coverage back to the date of loss of coverage. Premiums may be paid pretax beginning the first of the month following the date of the request. B. Letter does NOT have to say spouse/child lost dental or vision to add dental or vision. C. Employee may not make changes to coverage unless he adds spouse/child who lost health coverage. D. May not drop any coverage but may add coverage. E. If the spouse/child lost coverage through PEBA and he is then added to the employee's Dependent Life coverage, the effective date is the date of the loss or the first of the month following date of request, whichever is later.			

Special eligibility situations quick reference (cont.)

Event	This person/these people *(select one)*	Can do one or more of these actions *(select as many as apply)*	Effective date	Documentation required
Employee loses other dental coverage only (not health)	☐ Employee	☐ Enroll in dental	**Dental:** Date of loss of dental coverage	Verifiable confirmation from prior employer (letter, email, etc.) stating employee lost dental coverage and date of loss.
Employee loses other vision coverage only (not health)	☐ Employee	☐ Enroll in State Vision	**Vision:** Date of loss of vision coverage	Verifiable confirmation from prior employer (letter, email, etc.) stating employee lost vision coverage and date of loss.
Spouse or child loses other dental coverage only (not health)	☐ Employee and spouse/child who lost dental coverage	☐ Enroll in dental	**Dental:** Date of loss of dental coverage	Verifiable confirmation from prior employer (letter, email, etc.) stating spouse/child lost dental coverage and date of loss.
	Notes			
	A. Note about premiums: If the employee is enrolled in the MoneyPlus Pretax Group Insurance Premium feature, premiums must be paid post-tax for retroactive coverage back to the date of loss of coverage. Premiums may be paid pretax beginning the first of the month following the date of the request. B. If spouse/child not covered by employee for health, vision or life, dependent documentation is required. See Enrollment documentation worksheet.			

Special eligibility situations quick reference (cont.)

Event	This person/these people *(select one)*	Can do one or more of these actions *(select as many as apply)*	Effective date	Documentation required
Spouse or child loses other vision coverage only (not health)	☐ Employee and spouse/child who lost vision coverage	☐ Enroll in State Vision	**Vision:** Date of loss of vision coverage *If enrolled in MoneyPlus Pretax Premium feature, premiums must be paid post-tax for retroactive coverage back to the date of loss. Premiums may be paid through the Pretax Premium feature beginning first of the month following date of request.*	Verifiable confirmation from prior employer (letter, email, etc.) stating spouse/child lost vision coverage and date of loss.
	Notes			
	A. Note about premiums: If the employee is enrolled in the MoneyPlus Pretax Group Insurance Premium feature, premiums must be paid post-tax for retroactive coverage back to the date of loss of coverage. Premiums may be paid pretax beginning the first of the month following the date of the request. **B.** If spouse/child not covered by employee for health, vision or life, dependent documentation is required. See Enrollment documentation worksheet.			
Employee gains other health, dental or vision coverage	☐ Employee	☐ Drop coverage gained	**Health, dental, vision:** First of the month following gain of coverage or the first of the month if coverage is gained on the first of the month. **Medical Spending Account:** Change must be consistent with change reason	Verifiable confirmation from prior employer (letter, email, etc.) stating subscriber gained coverage and date of gain.
	Notes			
	A. Dependents enrolled in the same coverage must also be dropped. B. If subscriber drops Dental Plus, cannot remain enrolled in Basic Dental.			

Special eligibility situations quick reference (cont.)

Event	This person/these people *(select one)*	Can do one or more of these actions *(select as many as apply)*	Effective date	Documentation required
Spouse/child gains other health, dental or vision coverage	☐ Spouse/child who gained other coverage	☐ Drop coverage gained	**Health, dental, vision:** First of the month following gain of coverage or the first of the month if coverage is gained on the first of the month. **Medical Spending Account:** Change must be consistent with change reason	Verifiable confirmation from prior employer (letter, email, etc.) stating spouse/child gained coverage and date of gain.
	Notes			
	A. If subscriber drops Dental Plus, cannot remain enrolled in Basic Dental. B. Only the spouse/child listed on gain of coverage letter may drop.			
Employee gains Medicaid or CHIP coverage	☐ Employee	☐ Drop health ☐ Drop dental ☐ Drop vision ☐ Decrease MSA (cannot be lower than amount contributed or reimbursed, whichever is greater)	**Health, dental, vision**: **Exception to 31-day rule:** Employee has 60 days from the date notified by Medicaid of gain of coverage to drop health, dental and/or vision. • If notified by Medicaid within 60 days of gain of coverage, date of gain of Medicaid. • If notified by Medicaid more than 60 days after gain of coverage, first of month following request. (See Note B below).	Copy of Medicaid approval letter.
	Notes			
	A. Spouse or children enrolled in the same coverage will also be dropped. B. If the employee contacts PEBA later than 60 days after he was notified by Medicaid, no change can be made due to gain of Medicaid.			

Special eligibility situations quick reference (cont.)

Event	This person/these people *(select one)*	Can do one or more of these actions *(select as many as apply)*	Effective date	Documentation required
Spouse/child gains Medicaid or CHIP coverage	☐ Spouse/child who gained Medicaid or CHIP coverage	☐ Drop health ☐ Drop dental ☐ Drop vision ☐ Decrease MSA (cannot be lower than amount contributed or reimbursed, whichever is greater)	**Same as above**	Copy of Medicaid approval letter.
	Notes			
	A. Only the spouse/child listed on gain of coverage letter may drop. B. If the employee contacts PEBA later than 60 days after dependent was notified by Medicaid, no change can be made due to gain of Medicaid.			

Special eligibility situations quick reference (cont.)

Event	This person/these people *(select one)*	Can do one or more of these actions *(select as many as apply)*	Effective date	Documentation required
Employee loses Medicaid or CHIP coverage	If employee is not already enrolled in PEBA's health coverage: ☐ Employee ☐ Employee and spouse ☐ Employee and children ☐ Employee, spouse and children	☐ Enroll in health ☐ Enroll in dental ☐ Enroll in State Vision	**Health, dental and vision: Exception to 31-day rule:** • Employee has 60 days from the date notified by Medicaid of loss of coverage to enroll. If notified by Medicaid within 60 days, date of loss of Medicaid. • If notified by Medicaid more than 60 days after loss, first of month following request. (See Note D below).	Copy of Medicaid loss letter **and** Long-form birth certificate if adding child; marriage license or Page 1 of latest tax return if adding spouse.
	If employee is already enrolled in PEBA health coverage: Not eligible to change elections	Not eligible to change elections		
	Notes			
	A. Note about premiums: If the employee is enrolled in the MoneyPlus Pretax Group Insurance Premium feature, premiums must be paid post-tax for retroactive coverage back to the date of loss of coverage. Premiums may be paid pretax beginning the first of the month following the date of the request. B. Letter does not have to state spouse or children lost coverage to add them. C. May not drop any coverage but may add coverage. D. If the employee contacts PEBA later than 60 days after he was notified by Medicaid, no change is allowed.			
Spouse/child loses Medicaid or CHIP coverage	☐ Employee and spouse/child who lost health coverage	☐ Enroll in health (if employee already enrolled in health, may change plans if adding spouse or child to health) ☐ Enroll in dental ☐ Enroll in State Vision	**Same as above**	Copy of Medicaid loss letter **and** long-form birth certificate if adding child; marriage license or Page 1 of latest tax return if adding spouse.
	Notes			
	A. May add only the employee with the spouse/child who lost Medicaid. B. May not drop any coverage but may add coverage.			

Special eligibility situations quick reference (cont.)

<table>
<tr><th>Event</th><th>This person/these people (select one)</th><th>Can do one or more of these actions (select as many as apply)</th><th>Effective date</th><th>Documentation required</th></tr>
<tr><td rowspan="3">Employee gains premium assistance through Medicaid or CHIP</td><td>If employee is not already enrolled in PEBA's health coverage:
☐ Employee</td><td>☐ Enroll in health
☐ Enroll in dental
☐ Enroll in State Vision</td><td rowspan="2">Health, dental and vision: Exception to 31-day rule:
Employee has 60 days from the date notified of gain of Medicaid premium assistance to enroll.
• If notified by Medicaid within 60 days, date of gain of assistance.
• If notified by Medicaid more than 60 days after gain, first of month following request.

If enrolled in MoneyPlus Pretax Premium feature, premiums must be paid post-tax for retroactive coverage back to the date of loss. Premiums may be paid through the Pretax Premium feature beginning first of the month following date of request.</td><td rowspan="2">Copy of Medicaid approval letter</td></tr>
<tr><td>If employee is already enrolled in PEBA health coverage: Not eligible to change elections</td><td>Not eligible to change elections</td></tr>
<tr><td colspan="4">Notes
A. May not drop any coverage but may add coverage.
B. If the employee contacts PEBA later than 60 days after he was notified by Medicaid, no change can be made due to gain of Medicaid premium assistance.</td></tr>
<tr><td rowspan="2">Spouse/child gains premium assistance through Medicaid or CHIP</td><td>☐ Employee and spouse/child who gained Medicaid or CHIP premium assistance</td><td>☐ Enroll in health (if employee already enrolled in health, may change plans if adding spouse or child to health)
☐ Enroll in dental
☐ Enroll in State Vision</td><td>Same as above</td><td>Copy of Medicaid approval letter

and

Long-form birth certificate if adding child; marriage license or Page 1 of latest tax return if adding spouse</td></tr>
<tr><td colspan="4">Notes
A. May add only the employee with the spouse/child who receives Medicaid gain letter.
B. May not drop any coverage but may add coverage.</td></tr>
</table>

Special eligibility situations quick reference (cont.)

Event	This person/these people *(select one)*	Can do one or more of these actions *(select as many as apply)*	Effective date	Documentation required
Employee loses premium assistance through Medicaid or CHIP	☐ Employee	☐ Drop health ☐ Drop dental ☐ Drop vision	**Health, dental and vision:** **Exception to 31-day rule:** Employee has 60 days from the date notified of loss of Medicaid premium assistance to enroll. • If notified by Medicaid within 60 days, date of loss. • If notified by Medicaid more than 60 days after gain, first of month following request.	Copy of Medicaid loss letter
	Notes			
	A. If the employee drops coverage, spouse or children enrolled in the same coverage will also be dropped. B. If the employee contacts PEBA later than 60 days after he was notified by Medicaid, no change can be made due to loss of Medicaid premium assistance.			
Spouse/child loses premium assistance through Medicaid or CHIP	☐ Spouse/child who lost Medicaid or CHIP premium assistance	☐ Drop health ☐ Drop dental ☐ Drop vision	**Same as above**	Copy of Medicaid loss letter
	Notes			
	A. Only the spouse/child listed on loss of premium assistance letter may drop. B. If the employee contacts PEBA later than 60 days after he was notified by Medicaid, no change can be made due to loss of Medicaid premium assistance.			

Special eligibility situations quick reference (cont.)

Event	This person/these people *(select one)*	Can do one or more of these actions *(select as many as apply)*	Effective date	Documentation required
Employees not enrolled in the MoneyPlus Pretax Group Insurance Premium feature can also make the following changes:				
Marital separation *Requires a signed, filed court order from a jurisdiction that recognizes legal separation as a distinct legal status. As of the date of this publication, South Carolina does not.*	☐ Employee's separated spouse	☐ Drop health, dental and vision	First of the month following date of notification	Decree of Separate Maintenance or other order filed with court
	☐ Employee	☐ Enroll in or increase Optional Life up to $50,000 ☐ Cancel or decrease Optional Life	Optional Life: if employee is actively at work, first of month following date of request. If not actively at work, first of month after return to work.	
	Notes			
	A. Must notify within 31 days of court order or no election change can be made. B. If dropping a separated spouse, this is an all-or-nothing election change for all the benefits listed in Column 3. The employee may not choose among the options. C. For Optional Life, if employee is not actively at work on the expected effective date, then the effective date will be first of the month following return to work.			

Effective date quick reference

Type of action	Effective date
New hire	• If the employee begins active employment on the first day of the month, coverage begins on that day (on the 1st of the month). • If the employee begins active employment on the first working day of the month (first day that is not a Saturday, Sunday or observed holiday), but not on the first day of the month (for example, he begins on the 2nd or 3rd of the month), then the employee may choose when coverage begins: ○ The first day of that month, OR ○ The first day of the following month. • If the employee begins active employment after the first working day of the month (after the first day that is not a Saturday, Sunday or observed holiday), coverage will begin the first day of the following month.
Birth	**Health, dental and vision, and Dependent Life-Child**: Date of birth.
Adoption	**Health, dental and vision:** Date of adoption or placement for adoption, within 31 days of birth — then date of birth.
Foster care/guardianship	**Health, dental and vision:** Date of placement (usually date of court order).
Marriage	**Health, dental and vision:** Date of marriage.
Separation	**Health, dental and vision:** First of the month following date of notification.
Divorce	**Health, dental and vision:** First of month following divorce. **Dependent Life:** Date of divorce.
Employee loss of coverage	**Health, dental and vision:** Date of loss of coverage.
Spouse/child loss of coverage	**Health, dental and vision:** Date of loss of coverage.
Employee gain of coverage	**Health, dental, vision:** First of the month following gain of coverage or the first of the month if coverage is gained on the first of the month.
Spouse/child gain of coverage	**Health, dental and vision:** First of the month following gain of coverage or the first of the month if coverage is gained on the first of the month.

Effective date quick reference (cont.)

Type of action	Effective date
Employee gain of Medicaid or CHIP coverage or loss of premium assistance	**Health, dental and vision:** **Exception to 31-day rule:** • Employee has 60 days from the date notified by Medicaid of loss of coverage to enroll. • If notified by Medicaid within 60 days, date of loss of Medicaid. If notified by Medicaid more than 60 days after loss, first of month following request.
Spouse/child gain of Medicaid or CHIP coverage or loss of premium assistance	
Employee loss of Medicaid or CHIP coverage or gain of premium assistance	**Health, dental and vision:** **Exception to 31-day rule:** • Employee has 60 days from the date notified of gain of Medicaid premium assistance to enroll. • If notified by Medicaid within 60 days, date of gain of assistance. If notified by Medicaid more than 60 days after gain, first of month following request.
Spouse/child loss of Medicaid of CHIP coverage or gain of premium assistance	
Spouse/child of Foreign National Employee	Date of arrival in the U.S. to add; first of the month following departure from the U.S. to drop.
Late entrant (health) *(no medical evidence of good health)*	January 1 following open enrollment.
Ineligible spouse or child	First of the month after becoming ineligible.
Returning student	First of the month after becoming eligible.
Death (health, dental, SLTD)	One day after date of death.
Death (Optional Life)	Date of death.
Social Security number	N/A
Name	N/A
Address	N/A
Beneficiary changes (all plans)	Date of the signature on the NOE.
Optional Life increase throughout the year (not on MoneyPlus)	First of the month after approval of medical evidence. Deferred effective date provision applies.
Optional Life decrease or cancellation (not on MoneyPlus)	First of the month after request.
Optional Life increase due to special eligibility situation	See the Special Eligibility Situations Quick Reference charts.
Optional Life decrease or cancellation for MoneyPlus participants	See the Special Eligibility Situations Quick Reference charts.
Optional Life increase due to annual enrollment	Following January 1 for amount available without medical evidence, or first of month after approval of medical evidence if it is required for amount requested, whichever is later. Deferred effective date provision applies.
Optional Life decrease or cancellation due to annual enrollment	Following January 1.

Effective date quick reference (cont.)

Type of action	Effective date
Dependent Life-Spouse enrollment or increase throughout the year (when medical approval is required)	First of the month after approval. Deferred effective date provision applies.
Dependent Life-Spouse enrollment or increase due to special eligibility situation	See the Special Eligibility Situations Quick Reference charts.
Dependent Life-Child enrollment throughout the year	Date of birth for newborns. First of the month after date of request for other children. Deferred effective date provision applies to children other than newborns.
Retirement (service)	First of the month after retirement eligibility has been established.
Retirement (disability)	First of the month following the date on the approval letter from PEBA Retirement Benefits (disability retirement) or The Standard (BLTD/SLTD).

Documentation quick reference

Type of action	Documentation required
Administrative error	Statement explaining error and circumstances on a request for review, with any supporting documentation attached.
Adoption/placement for adoption	Copy of a birth certificate listing the subscriber as the parent; or a copy of legal adoption documentation from the court, verifying the completed adoption; or a letter of placement from an attorney, adoption agency or DSS, verifying the adoption in progress.
Divorce Decree or Court Order to Insure Ex-spouse or Child(ren)	Copy of the entire divorce decree or court order. Document must stipulate the programs under which the spouse or child must be covered.
Custody or Guardianship of Child(ren)	Copy of court order or other legal documentation from a placement agency or DSS, granting custody or guardianship of a child/foster child to the subscriber. The documentation must verify the subscriber has guardianship responsibility for the child and not merely financial responsibility.
Death in the line of duty	Verification of death while on duty.
Dependent Life (adding or increasing when medical evidence is required)	Copy of approval from MetLife.
Divorce Decree (drop spouse)	Copy of the entire divorce decree *(See also Divorce Decree or Court Order to Insure Former Spouse or Child(ren) above).*
Divorce or annulment of married child (to add child) (For Dependent Life only)	Copy of divorce decree or documentation of annulment, along with proof of eligibility as a full-time student or incapacitated child, if child is age 19 or older.
Enrolling a child	Copy of the long-form birth certificate showing the subscriber as the parent.
Enrolling a spouse	Copy of marriage license or Page 1 of latest federal tax return if filling jointly.
Enrolling a stepchild	Copy of the long-form birth certificate showing name of natural parent plus proof natural parent and subscriber are married.
Foreign national	Copy of entry stamp/departure stamp from visa.

Documentation quick reference (cont.)

Type of action	Documentation required
Gain Medicare coverage	Copy of Medicare card.
Gain/Loss Medicaid coverage	Letter from the Department of Health and Human Services, confirming Medicaid approval and effective date or confirming Medicaid coverage is ending and the effective date.
Gain/Loss other coverage	Copy of creditable coverage letter or verifiable confirmation from prior employer (letter, email, etc.) that includes: Date coverage gained/lost, individuals who gained/lost coverage, type(s) of coverage gained/lost and reason for gain/loss.
Incapacitation	*Incapacitated Child Certification Form*, completed by both the subscriber and the child's physician. For Dependent Life only, if child is ages 19-24, must also include letter from educational institution, confirming withdrawal from school as a full-time student.
Medicare correction	Copy of Medicare card.
Medicare due to disability	Copy of Medicare card.
Military activation	Copy of military orders.
Military — return from duty	Copy of military discharge papers.
Name change	Copy of driver's license, Social Security card, order of name change or vital records certificate.
Optional Life (adding or increasing when medical evidence is required)	Copy of approval from MetLife.
Retirement — Disability	Copy of approval letter from the S.C. Retirement Systems or Standard Insurance Company.
Retirement — Service	Copy of signed *Employment Verification Record* form.
Separation (to drop spouse)	Copy of a court order, signed by a judge. The court order must state that the divorce is in progress. *Cannot be done outside open enrollment or finalized divorce by subscribers with MoneyPlus.*
SSN Correction	Copy of Social Security card.
Student Certification	Statement on letterhead, from the educational institution, stating student is full time and dates of enrollment.
Supplemental Long Term Disability (adding/increasing when medical evidence is required)	Copy of the approval from The Standard.

Active Termination Form quick reference

Submit terminations through EBS when permissible.

Action	Employee Information	Coverage/Dates	Certification
NOT ELIGIBLE: enter last day worked and check applicable reason	#1-7	Effective date and all plans in which enrolled.	COBRA and/or Conversion for OL (if applicable). Sign and date.
TRANSFER TO: new group ID # and group name	#1-7	Effective date and all plans in which enrolled.	COBRA and/or Conversion for OL (if applicable). Sign and date.
MILITARY LEAVE	#1-7	Effective date and all plans in which enrolled.	COBRA and/or Conversion for OL (if applicable). Sign and date.
NONPAYMENT	#1-7	Effective date and all plans in which enrolled.	Conversion for OL (if applicable). Sign and date.
SERVICE RETIREMENT: must meet criteria for PEBA Retirement Benefits and retiree insurance	#1-7	Effective date and all plans in which enrolled.	COBRA, Retiree and Conversion or Continuation for OL (if applicable). Sign and date.
DISABILITY: approved for BLTD/SLTD and/or PEBA Retirement Benefits disability	#1-7	Effective date and all plans affected by termination (OL can be continued). Do not terminate OL if in waiver; complete OL waiver form.	COBRA, Retiree and Conversion or Continuation for OL (if applicable). Sign and date.
DECEASED: enter date of death	#1-7	Effective date and all plans in which enrolled.	Sign and date only.

Affordable Care Act glossary

New full-time employee (Permanent or Nonpermanent)	A newly hired employee who was determined by the employer, as of the date of hire, to be full-time and eligible for benefits.
New variable-hour, part-time or seasonal employee	A newly hired employee who is not expected to be credited an average of 30 hours per week for the entire measurement period, as of the date of hire. Therefore, the employer cannot reasonably determine his eligibility for benefits as of the date of hire.
Ongoing employee	Any employee who has worked with an employer for an entire Standard Measurement Period.
Plan year	January 1 to December 31.
Applies to new variable-hour, part-time and seasonal employees	
Initial Measurement Period	Begins the first of the month after the date of hire and ends 12 months later. The employer should review the employee's hours over the Initial Measurement Period to determine future eligibility for benefits.
Initial Administrative Period	Begins the day after the initial measurement period ends and ends the last day of the same month. The employer uses this time to review the employee's hours over the initial measurement period, and, if the employee is eligible, offers benefits to the employee the first of the following month.
Initial Stability Period	Begins the day after the Initial Administrative Period ends and lasts for 12 months. This is the period of time that an employee cannot lose eligibility for benefits regardless of the number of hours he works. If the employee is deemed eligible for coverage during the Initial Administrative Period, he remains eligible for 12 months as long as he remains employed by the employer.
Applies to all ongoing employees	
Standard Measurement Period	Begins on October 4 and ends 12 months later, on October 3. The employer will review the employee's hours over the Standard Measurement Period to determine eligibility for the upcoming plan year.
Administrative Period	Begins on October 3 and ends December 31. This is the period of time an employer and the plan have to identify and enroll eligible individuals in coverage. Employers must offer coverage to eligible employees during the plan's open enrollment period, which ends October 31. PEBA uses the remainder of the Administrative Period to process enrollments to ensure employees have access to coverage at the beginning of the Stability Period.
Stability Period	Begins on January 1 and ends 12 months later on December 31. This is the period of time that an ongoing employee cannot lose eligibility for benefits regardless of the number of hours he works. If the employee is deemed eligible for coverage during the Administrative Period, he remains eligible for the entire plan year as long as he remains employed with the employer.

For more information on the Affordable Care Act, including frequently asked questions, go to peba.sc.gov/aca.

Quick reference calendar for determining eligibility

This chart helps determine eligibility for new variable-hour, part-time and seasonal employees. After an employee has been employed for a full Standard Measurement Period, he becomes an ongoing employee, and his hours should be reviewed during the open enrollment period (with all other ongoing employees) to determine his eligibility for benefits in the next plan year.

Month employee began work	Initial Measurement Period (*12 months*)	Administrative Period	Initial Stability Period (*12 months*)
	Begins the 1st of the month after the date of hire. During this period, an employer would measure the employee's hours.	*Immediately follows the Initial Measurement Period. Employer should review the hours worked during the Initial Measurement Period. If the employee averages 30 hours or more per week, he is eligible for benefits.*	*Immediately follows the Administrative Period. If the employee is deemed eligible for benefits during the Administrative Period, this is the period of time the employee remains eligible for benefits regardless of the number of hours worked.*
January	Feb. 1-Jan. 31	Feb. 1-28	March 1-Feb. 28
February	March 1-Feb. 28	March 1-31	April 1-March 31
March	April 1-March 31	April 1-30	May 1-April 30
April	May 1-April 30	May 1-31	June 1-May 31
May	June 1-May 31	June 1-30	July 1-June 30
June	July 1-June 30	July 1-31	Aug. 1-July 31
July	Aug. 1-July 31	Aug. 1-31	Sept. 1-Aug. 31
August	Sept. 1-Aug. 31	Sept. 1-30	Oct. 1-Sept. 30
September	Oct. 1-Sept. 30	Oct. 1-31	Nov. 1-Oct. 31
October	Nov. 1-Oct. 31	Nov. 1-30	Dec. 1-Nov. 30
November	Dec. 1-Nov. 30	Dec. 1-31	Jan. 1-Dec. 31
December	Jan. 1-Dec. 31	Jan. 1-31	Feb. 1-Jan. 31

Quick reference for unpaid leave or reduction in hours

This information describes how eligibility for insurance benefits is affected when an employee goes on an employer-approved leave of absence that is not associated with military leave or FMLA.

Employee's status	When unpaid leave (or reduction of hours) begins	Premium information	Employee's options	When employee returns from unpaid leave (or hours are increased)
Ongoing Employee (in a stability period) or variable-hour, part-time and seasonal employee (in an Initial Stability Period)	Eligibility for health, dental and vision continues through the end of the stability period. Employer should send the employee the *Your Insurance Benefits When Your Hours are Reduced* form.	Employee pays employee's share; employer pays employer's share. If employee fails to pay within the grace period, employer can submit termination to PEBA to terminate coverage. Employee is not eligible for COBRA.	Employee may choose to voluntarily drop coverage to enroll in the Marketplace. If employee elects to drop coverage for this reason, employer should submit termination to PEBA. Choose Reduction in Hours in EBS.	If employee continued coverage while on unpaid leave, no action required.* If employee voluntarily dropped coverage to enroll in Marketplace (or if coverage was terminated due to nonpayment), employee can enroll within 31 days of special eligibility situation or during open enrollment (if eligible). *If SLTD or life insurance were terminated, employee may enroll with medical evidence.
New variable-hour, part-time or seasonal employee (Not in a stability period)	Employee's eligibility has not yet been established.	N/A	N/A	If employee returns to work with same employer as a variable-hour, part-time or seasonal employee: Less than a 13-week break (26-weeks if academic employer), the initial measurement period continues. 13-week break or more (26-week break or more if academic employer), the initial measurement period begins the first of the month following return to work.
New full-time employee (Employee is not in a stability period nor on FMLA nor on military leave)	Eligibility for active benefits ends first of the month following employee's last day of paid work or first of the month following his reduction of hours. Employer sends employee the *Your Insurance Benefits When Your Hours are Reduced* form. Employer submits termination to PEBA and sends the 18-month COBRA notice to employee.	Refer to COBRA rates	Employee and covered dependents may continue coverage through COBRA for up to 18 months (COBRA qualifying event is reduction of hours). Submit termination to PEBA. Choose Left Employment in EBS.	Eligibility for active benefits begins the first of the month following the employee's return to work or resumption of working 30 hours per week.

Premium checks quick reference

Type of employer	Submitting insurance checks to PEBA Insurance Finance		
	Active employee	**Unpaid leave**	**Retiree/COBRA/Survivor**
Optional employer	Single check from employer of all active premiums as billed by PEBA Insurance Finance.	Single check from employer; include with active group as billed. Do not send personal employee checks to PEBA Insurance Finance.	Include all premiums for these subscribers in the single check for active employees. Do not send personal employee checks to PEBA Insurance Finance.
School districts and public higher education institutions	Single check from employer of all active premiums as billed by PEBA Insurance Finance.	Single check from employer; include with active group as billed. Do not send personal employee checks to PEBA Insurance Finance.	PEBA Insurance Finance bills subscribers. Subscribers submit personal checks to PEBA Insurance Finance or have premiums deducted from PEBA retirement benefits annuity payment or other account.
CG agency	Employee and employer premiums are payroll-deducted by SCEIS and sent directly to PEBA Insurance Finance.	Submit personal employee checks, payable to PEBA Insurance Finance.	PEBA Insurance Finance bills subscribers. Subscribers submit personal checks to PEBA Insurance Finance or have premiums deducted from PEBA retirement benefits annuity payment or other account.

Employer checklists

Comprehensive PEBA employer checklists for life events are available at peba.sc.gov/publications.

- Enrolling a new hire.
- Adding a dependent due to marriage.
- Adding a dependent due to birth.
- Adding a dependent due to adoption.
- Dropping a dependent due to divorce.
- Leaving employment before retirement eligibility.
- Service retirement.
- Disability retirement.
- Death of a covered employee.
- Death of a covered dependent.

Coverage termination processes

Termination of employment due to resignation, RIF, dismissal

Effective date is the first of the month after the last day worked.

- ☐ Submit termination to PEBA immediately. Do not delay!
  - EBS termination: Left employment.
  - *Active Termination Form*: Not eligible (T5) Complete an Active Termination Form.
- ☐ Offer the employee and his spouse and/or children COBRA enrollment information by letter.
- ☐ Refer to the *COBRA subscribers* section of this manual for additional information.

ASIFlex will send the Medical Spending Account COBRA qualifying event letter to the employee if he qualifies for COBRA continuation. The employee may continue a Medical Spending Account for the rest of the year on an **after-tax basis** through COBRA by electing coverage and paying monthly amounts in a timely manner.

If the terminating employee's spouse is a covered employee or retiree, the terminating employee may be added to the spouse's coverage and other eligible programs within 31 days. If enrolled within 31 days:

- The employee may convert Basic Life, Optional Life, Dependent Life-Spouse and/or Dependent Life-Child coverage.
- The employee may convert SLTD coverage if he meets the criteria.
- If eligible, the employee may continue to contribute to a Health Savings Account directly through Central Bank.

Termination of employment with transfer to another PEBA-participating employer

- ☐ Submit termination to PEBA immediately. Do not delay!
  - EBS termination: Transfer.
  - *Active Termination Form*: Transfer (TT).

  Include the group name and number to which the employee is transferring.
- ☐ Offer the employee and his spouse and/or children COBRA enrollment information by letter.
- ☐ Refer to the *COBRA subscribers* section of this manual for additional information.

Refer to the *Transfers and Terminations* section of this manual for additional information.

Termination of employment due to retirement (service or disability)

Effective date is the first of the month after retirement eligibility has been established. If it is a disability retirement, the effective date will be the first of the month following the date on the approval letter from PEBA Retirement Benefits or The Standard (BLTD/SLTD) in certain situations.

For more information on retirement eligibility refer to the *Insurance Benefits Guide*.

- ☐ Submit termination to PEBA immediately. Do not delay!
  - EBS termination: Retired or Disability retired.
  - *Active Termination Form*: Service retirement (T7) or Disability retirement (T2).
- ☐ Provide the *Retiree Packet* to the employee. The required forms for establishing eligibility, enrolling in retiree insurance and certifying tobacco use are included in the packet.
  - Document in the employee's file the date you provided or mailed the *Packet*.
- ☐ Offer the employee and his spouse and/or children COBRA enrollment information by letter.
- ☐ Refer to the *COBRA subscribers* section of this manual for additional information.

ASIFlex will send the Medical Spending Account (MSA) COBRA qualifying event letter to the employee if he qualifies for COBRA continuation. The employee may continue the MSA for the rest of the year on an **after-tax basis** through COBRA by electing coverage and paying the monthly amounts in a timely manner.

The employee may continue the MSA for the rest of the year on a **pretax basis** if:

- The employee declined COBRA continuation coverage;
- The employee elected in advance, on his last enrollment form, to accelerate his pretax deductions up to the full, annual amount; or
- The remainder of his full, annual election was deducted from his final paycheck(s).

Refer to the *Retiree subscribers* section of this manual for additional information.

Termination due to death of subscriber

Effective date is the day after date of death, except for Optional Life (date of death).

- ☐ Submit termination to PEBA immediately. Do not delay!
  - EBS termination: Death.
  - *Active Termination Form*: Deceased (T1).

  Forward a copy of the death certificate/documentation to PEBA immediately.
- ☐ Complete the *Life insurance claim form* and send along with coverage verification and beneficiary information to MetLife. If the death was accidental, attach the police/accident report, newspaper article, etc., and write Accidental at the top of the form.
- ☐ If the employee was receiving disability benefits, send a copy of the *claim form* to The Standard so that any potential benefits may be paid to eligible survivors**.**
- ☐ Explain survivor benefits to any covered spouse and/or children.

Refer to the *Survivors* section of this manual for additional information.

Termination due to non-payment of premiums

Effective the first of the month following the last month in which premiums were due and paid in full.

- ☐ Submit termination to PEBA immediately. Do not delay!
  - *Active Termination Form*: Nonpayment (TN).

Optional employers should complete the appropriate termination for Retiree, COBRA and Survivor subscribers.

Do not send COBRA notification letters because COBRA does not apply.

If the employee returns to work after coverage has been terminated, reinstatement of coverage must be requested within 31 days of returning to work. Otherwise, the employee and any eligible spouse and/or children must wait until the next open enrollment period or until a special eligibility situation occurs and enroll as late entrants. Returning to work is **not** a special eligibility situation that allows an employee to re-enroll in benefits.

Termination during military leave

- ☐ Submit termination to PEBA immediately. Do not delay!
  - *Active Termination Form*: Military leave (TM).
- ☐ If not continuing coverage during leave, refer to the information in Military Leave in the Active subscribers' chapter.

  A copy of the employee's military orders is required.

  If the employee does not continue coverage during military leave, refer to the *Military Leave* information in the *Active subscribers* section of this manual. Coverage may be reinstated within 31 days of returning to work.

Termination of covered spouse and/or child

Coverage changes must be made within 31 days of a special eligibility situation. *Exception*: **State Vision Plan.** Coverage changes may be made during the next October enrollment period.

- ☐ Submit in EBS or complete a paper *Active Notice of Election* to terminate coverage and change coverage level, if applicable.
  - Upload or attach any supporting documentation, if applicable. If submitting on paper and, if the subscriber's tobacco-use status has changed, attach a completed *Certification Regarding Tobacco or E-cigarette Use* form.
- ☐ Offer the employee and his spouse and/or children COBRA enrollment information by letter. Refer to the *COBRA subscribers* section of this manual for additional information.
- ☐ If the spouse or child is covered under Dependent Life insurance, that coverage can be converted.

Death of covered spouse or child

- ☐ Complete an Active NOE to terminate coverage of a deceased spouse or child and change coverage level, if applicable.
  - *Effective date:* Day after death.
  - Forward a copy of the form to PEBA.
- ☐ Complete the *Life Insurance Claim* form and send it, along with coverage verification and beneficiary information, to MetLife for Dependent Life benefits.
- ☐ If applicable, complete *Notice of Election* form and send to PEBA if the employee is making a change to his Medical Spending or Dependent Care Spending account.

Retiree orientation checklist

Determining retiree insurance eligibility is complicated, and only PEBA can make that determination. Provide the Retiree Packet to the employee.

Explain that enrollment in retiree insurance coverage is not automatic. To enroll in retiree insurance, he will first need to confirm his eligibility for retiree group insurance by completing and submitting an *Employment Verification Record* to PEBA. This may be done up to six months prior to his anticipated retirement date. It is very important to contact PEBA before making final arrangements for retirement.

If PEBA determines that he is eligible for retiree insurance coverage, he must complete and submit the *Retiree Notice of Election* and any other applicable forms within 31 days of his retirement date. These completed forms should be submitted to PEBA for state agency, public school district or higher education institution employees. These forms may be submitted to the employer's benefits office for optional employers.

At retirement, MetLife will mail a conversion/continuation packet. The packet will include instructions for available options. Call MetLife at 888.507.3767 if the retiree does not receive the packet.

Refer to the *Retiree group insurance* chapter of the IBG for a detailed description of benefits for retirees. Medicare-eligible retirees should refer to the *Insurance Coverage for the Medicare-eligible Member* handbook.

Explain optional employer funding, if applicable.

Health insurance

- ☐ Review options and benefits.
    - If the employee and his eligible spouse and/or children are not eligible for Medicare, he cannot choose the Medicare Supplemental Plan.
    - If eligible for, or enrolled in, Medicare:
        - Enroll in Part A **and** Part B for maximum coverage and to avoid the carve-out method of claims payment. The employee must notify his employer and PEBA as soon as he becomes eligible.
        - Subscribers covered by the Medicare Supplemental Plan or the Standard Plan will be automatically enrolled in the State Health Plan Medicare Prescription Drug Program, a group-based Medicare Part D Prescription Drug Plan (PDP). In most cases, a retiree will be better served if he remains enrolled in the Medicare Part D plan sponsored by PEBA. If the retiree enrolls in a separate Part D plan, he loses prescription drug coverage with his plan through PEBA.
        - If eligible for Medicare, the retiree is no longer eligible for the Savings Plan or an HSA.
- ☐ If the tobacco-use status for the retiree is changing, attach a *Certification Regarding Tobacco or E-cigarette Use* form to the *Retiree NOE*.
- ☐ Must wait until next open enrollment period or special eligibility situation if **not** enrolled within 31 days of retirement date.

Dental Plus and Basic Dental

- ☐ Review options and benefits.
- ☐ Must wait until next open enrollment period of an odd-numbered year or special eligibility situation if **not** enrolled within 31 days of retirement date.

State Vision Plan

- ☐ Review State Vision Plan benefits.
- ☐ Must wait until next open enrollment period or within 31 days of loss of other vision coverage if **not** enrolled within 31 days of retirement date.

Life insurance

- ☐ If the employee is eligible for retirement benefits through PEBA, he may choose to continue OR convert his Optional Life coverage with MetLife.
    - MetLife will mail a conversion/continuation packet via U.S. mail three to five business days after MetLife receives the eligibility file from PEBA.
    - To continue coverage, the retiree must complete the form that will be included in his packet from MetLife. Coverage must be elected within 31 days of the date coverage is lost due to approved retirement or approved disability retirement.
    - To convert coverage, the retiree must follow the instructions in the packet from MetLife. Coverage must be converted within 31 days of the date coverage is lost due to approved retirement or approved disability retirement. It is the retiree's responsibility to contact MetLife regarding conversion.

Long term disability

- ☐ Basic Long Term Disability coverage ends at retirement.
- ☐ Supplemental Long Term Disability coverage ends at retirement.

MoneyPlus

- ☐ MoneyPlus is **not** available in retirement (HSA exception below). Generally, an employee's period of coverage for the flexible spending accounts will end at retirement, with this exception:
    - A Medical Spending Account participant may accelerate his pretax deductions, to extend his period of coverage through the end of the plan year. Otherwise, he may continue coverage on an after-tax basis through COBRA as explained in the IBG.
- ☐ A retiree may continue to contribute to an HSA as long as enrolled in the Savings Plan (or other high deductible health plan) as sole coverage, until eligible for Medicare. Contributions in retirement are paid directly to Central Bank or other HSA custodian, not through payroll deduction or ASIFlex.

Additional information to explain

- ☐ The retiree will receive from PEBA:
    - A letter confirming retiree coverage.
    - A Certificate of Creditable Coverage, since active benefits are ending.
    - A COBRA notification letter, since active benefits are ending. (BA to send the Qualifying Event Notice according to procedures in COBRA subscribers' chapter.)
- ☐ Premiums for health, dental and vision may be paid directly from his PEBA Retirement Benefits annuity payment, if the annuity payment is enough to cover the premiums.
    - *Exception*: PEBA bills optional employers and those retirees who are not yet receiving annuity payments from PEBA Retirement Benefits.
    - Retirement benefits are paid at the end of the month, for that month (in arrears). However, insurance premiums are deducted at the end of the month, for the next month (in advance).
    - Based on the effective date of retirement, when the Retiree NOE is submitted and processing time, more than one month's premiums may be deducted from the first retirement check.

- ☐ If retiring due to disability, a copy of the disability approval letter from PEBA Retirement Benefits or Standard Insurance Company must be sent to PEBA as soon as it is received. The effective date for insurance purposes will be the first of the month following the date on the approval letter from PEBA Retirement Benefits or The Standard (if retiree is a State ORP participant or if employer is not a covered employer through PEBA Retirement Benefits).

Disability checklist

- ☐ The employee should complete and submit an Application for Disability Retirement to PEBA Retirement Benefits, if applicable. The BA may apply on behalf of the employee if he is unable to do so.
- ☐ The employee should complete and submit a Long Term Disability Claim Form packet to The Standard. The BA may apply on behalf of the employee if he is unable to do so.
- ☐ SLTD premium waiver begins the first of the month after the end of the benefit waiting period. Premiums should continue until then. The Standard will contact PEBA, the BA and the employee after approving the claim.
- ☐ The employee may continue MoneyPlus while on disability leave. If the employee does not wish to continue MoneyPlus, notify ASIFlex via the employer portal that the employee is on leave and will not be continuing his contributions.
- ☐ If the employee returns to work after a disability:
- ☐ Complete and send the SLTD Premium Waiver Form to PEBA.
- ☐ Contact The Standard.

For more information, see Disability Subscribers.

Claims checklist

- ☐ Make sure you are using the proper claim form for the program as instructed in the Claims and appeals chapter.
- ☐ Be certain that each required section has been completed and the information is legible and correct.
- ☐ Make sure the claimant's name is listed exactly as it is on the NOE or in EBS.
- ☐ Ensure that the SSN or BIN of the employee/retiree is used for himself and for his covered spouse and/or children. The providers use individual Medicare numbers when filing for health benefits through Medicare, with Medicare as the primary payer.
- ☐ Attach proper and complete documentation as requested, based on the type of claim.
- ☐ Send the completed claim form to the address listed on the form.
- ☐ For MoneyPlus flexible spending account claims, keep a copy of the MoneyPlus Claim Form, including any itemized receipts or explanation of benefits statements. HSA participants are responsible for maintaining their own documentation.

Accounting system checklist

- ☐ All balances are due to PEBA on the 10th of the month and must be paid as billed. Do not adjust the billing statement.
- ☐ Payment is due as billed. The collection of premiums has no bearing on payment. Do not delay the regular remittance of monthly premiums due to failure to collect payments from subscribers.
- ☐ Employers must pay no less than the current employer share of the premiums for their active employees.
- ☐ All payments should be made payable to PEBA. If your office also pays for retiree, survivor and COBRA subscriber coverage, submit a separate check for these premiums. See Submitting Premium Payments to PEBA on Page 142.
- ☐ You must return a completed remittance advice form with every payment. Do not return any other section of the billing statement with your payment.
- ☐ Use the return envelope provided, or mail your payment to PEBA's Financial Services Department using the following mailing address:
  S.C. PEBA
  Attn: Insurance Finance Department
  P.O. Box 11661
  Columbia, SC 29211
- ☐ If there is a keying error on the coverage processing section of the bill, please call the Customer Contact Center at 803.737.6800 or 888.260.9430.
- ☐ If you have a question about the Account Summary or Billing Summary, call PEBA's Financial Services Department at 803.734.1696 or 888.260.9430.
- ☐ Payment of one month's advance billing is due by July 15 of each year for active employees. The advance billing is the total employer contribution for health, dental, life and LTD as determined by PEBA enrollment files for July.

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PEBA℠
SC Retirement Systems
and State Health Plan

South Carolina Public Employee Benefit Authority

Serving those who serve South Carolina

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